as
Health
1973

CONSUMER PARTICIPATION
REGULATION OF THE PROFESSIONS
DECENTRALIZATION OF HEALTH SERVICES

LEGISLATIVE LIBRARY
WITHDRAWN
SEP 21 1973
RECEIVED

A REPORT SUBMITTED TO THE MINISTER
OF PUBLIC HEALTH, SASKATCHEWAN.

BY J.T. McLEOD RESEARCH ASSOCIATES LTD.

AUGUST, 1973.

Minister of Public Health

REGINA, Saskatchewan

August 14, 1973

To Saskatchewan Health Agencies and
Health Professional Organizations

Attached is a report on the subject of "Consumer Participation; Regulation of the Professions; and Decentralization of Health Services" which I have recently received from Professor J.T. McLeod of the University of Toronto.

In 1972 I invited Professor McLeod to review contemporary thought on the three main topics raised in his report, and consider these topics in a Saskatchewan context. I felt it would be helpful to all of us involved in the field of health to have these very complex subjects placed before us in a document which could then be used to stimulate wide ranging discussion and comment in Saskatchewan.

In releasing this document to the public, I would like to emphasize that the conclusions and recommendations do not represent either governmental or departmental policy. This report is intended as a vehicle to open public discussion in Saskatchewan on these important topics.

Dr. J.T. McLeod is a Professor of Political Economy at the University of Toronto. He is a former Saskatchewan resident and researcher who has maintained his interest in this province over many years. On health related issues, Professor McLeod has contributed as a thinker and as a consultant to several governments in Canada and to a number of distinguished commissions and committees.

I am pleased that mutually we shall be able to examine the concepts of consumer participation in the health field, regulation of the health professions, and decentralization of health services. Obviously these concepts have considerable importance to all of us.

Yours sincerely,

Walter E. Smishek

CATALOGUED

FOR DISCUSSION
AND
COMMENT ONLY

CONSUMER PARTICIPATION

REGULATION OF THE PROFESSIONS

AND DECENTRALIZATION OF HEALTH SERVICES

A Report submitted to the Minister
of Public Health, Saskatchewan,
by Professor J. T. McLeod,
Department of Political Economy,
University of Toronto, and
J. T. McLeod Research Associates Ltd.

August, 1973.

135899

TABLE OF CONTENTS

		PAGE NO.
Part I	THE POLICY FRAMEWORK AND FUTURE DIRECTIONS OF HEALTH CARE	
	1. Thinking About Health Services: A Perspective	1
	2. Goals and Objectives	6
	3. The Problem of Cost Control	9
	4. Future Directions of Health Service	15
	5. Planning, Necessary Inter-Relations of the Planning Framework	21
	6. Current Planning in Manitoba THE "STAY OPTION"	25
	7. The Basic Design	27
Part II	CONSUMER PARTICIPATION	
	1. The Present System and the Position of the Consumer	30
	2. Consumer Participation - WHY?	37
	3. A Digression on Radical Theory	41
	4. Consumer Participation - WHO?	46
	5. Consumer Participation - HOW?	51

PAGE NO.

Part III PUBLIC REGULATION OF THE PROFESSIONS

1. Introduction 56
2. The Case for Professional Self-Government 60
3. The Role of the State in the Professional Regulation 64
4. The Case for Increased Public Regulation of Professions 67
5. Precedents in Ontario 80
6. Precedents in Quebec 89
7. The Hastings Report Recommendations on Regulation 98
8. Review of Existing Saskatchewan Health Professions Acts 103
9. Recommendations 110

Part IV REGIONALIZATION

1. The Case for Centralization 114
2. The Case for Regionalization 116
3. A Semantic Confusion and a Warning 121
4. Approaches to Regionalization in Ontario 125
5. Approaches to Regionalization in Quebec 143
6. Recent Federal Proposals 150
7. The Proposed Scheme for Saskatchewan - COMMUNITY HEALTH CENTRES 155
8. The Proposed Scheme for Saskatchewan - METHODS OF PROVINCIAL CONTROL 170
9. The Proposed Scheme for Saskatchewan - REGIONALIZATION 189
10. RECOMMENDATIONS 212

PART I

THE POLICY FRAMEWORK AND FUTURE DIRECTIONS OF HEALTH CARE

I. THE POLICY FRAMEWORK AND FUTURE DIRECTIONS OF HEALTH CARE

1. Thinking About Health Services: A Perspective

Problems of health care are often discussed as though they were entirely unique, existed in a vacuum, and could not usefully be compared or contrasted with any other aspect of modern society. This is one reason why many people have such difficulty *thinking* about innovations in health services.

True, medicine is an extremely sophisticated discipline; on many subjects, often involving life and death, the physician does know best, and laymen must defer to medical judgement. The skills and knowledge of the physician are extremely valuable to society, and ought not to be interferred with lightly by the state.

But physicians have no monopoly on knowledge concerning the organization, financing, and delivery of health services. Methods of organizing and integrating health care are as much a part of medical *technology* as is open heart surgery. Knowledge, without means of disseminating and applying it to the needs of the community, is socially useless. Thus, the knowledge of the economist, the administrator, or the public health nurse must also be regarded as significant aspects of health technology.

Moreover, throughout North America there is evidence of growing concern by patients and the general public over

issues of health care. Questions of rising health costs, accessibility of services, and quality of care now occupy public attention. In the field of health as in many other areas, consumers - the increasingly sophisticated lay public - are eager to have some voice in the determination of what they are able to buy through their private expenditures and their tax dollars.

Because medical science does not exist in a social vacuum, there are important precedents and parallels drawn from other fields of knowledge which can shed much light on problems of health care. These problems may be seen in better perspective if they are examined together with another basic public utility which has been organized and financed by government for a much longer time, namely: education.

If we look at educational services together with health services, a number of lessons and instructive parallels instantly leap to mind.

- Public or state involvement has not diminished the quality of education. Far from it. The quality (as well as the quantity and distribution) of education has been significantly improved during the past 50 or 100 years.

- It is now quaint and obsolete to talk of "public" and "private" education. Since almost the total school and

university bill is picked up by the taxpayer, there is nothing *but* public education now in Canada. Is it not folly to continue to make artificial distinctions between "public" and "private" health care? Surely there is only "health care"; "private" health care cannot be regarded as private any more.

- Similarly, it would be silly to discuss "deterrent fees" for high schools. We want more and better education, and we want to reduce rather than raise financial barriers inhibiting access to this service. The same is true of health.

- In terms of personnel or practitioners, we have long ago rejected the notion that there can be only one kind or level of "teacher". Not every teacher is a "doctor" of pedagogy or a Ph.D. We do not insist upon Ph.D.s or even M.A.s for every Grade Four or Grade Nine classroom. Instead, we use a judicious *mix* of skills and levels of training for the delivery of educational services.

- Public regulation and public accountability of the teaching profession are accepted facts. Peer group review of teaching performance is an important aspect of quality control.

- It would be laughable to talk of *"fee-for-service"* teaching or "solo-practitioners" in the schools; education has been collectivized and institutionalized; teachers work in teams and groups. Similar trends are now evident in health care.

- Teachers work on *salaries*. These salaries are of course negotiated rather than set unilaterally by teachers' associations. For teachers, the only real question is not salary *vs.* fee-for-service, but rather "how much salary", with what amount of release-time for continuing education, community service, and leisure? In fact, it *has* proven possible to combine the principle of salaried remuneration with the highest degree of *professional freedom and autonomy*: teachers and professors, working on salaries, probably enjoy as much intellectual and professional liberty as can be found in contemporary society, and that professional freedom is jealously guarded.

- We no longer fuss about "consumer control" of education, but have long ago accepted public boards of trustees and elected school boards. Generally, these public boards control and supervise the organization and *ends* of the school system, and refrain from interference with the *means* of education (what goes on in the classroom

between students and teachers) unless flagrant abuses occur. We are responding to student demands for participation on the decision-making bodies of universities. Consumer influence is an accepted fact, and the educational system has not been crushed or corrupted by it.

- The consumers and taxpayers, taking public control of education for granted, have now begun to ask why there is so much waste and duplication in the expensive educational system, why there is not more practicality, flexibility, and "social relevance" to academic programmes and curricula. Since the public is paying the shot, it seems certain that the public will demand change and get what it wants. Again, the comparison with health services is obvious.

- There are of course, places where the health-education analogy breaks down, but with all of these striking parallels in mind, it seems odd that the field of health services should continue to be characterized by so much confusion and puzzlement over elementary principles such as "consumer participation", new methods of payment, changing patterns of organization and practice, or archaic, artificial distinctions between "public"

and "private". There are no easy roads to Utopia in either education or health. However, if we do not shift gear intellectually and ideologically, if both governments and practitioners cling to rigid concepts of "absolute state control" or "absolute professional autonomy", socially useful innovation will be delayed, and the process of change will be scarred by needless conflict.

2. Goals and Objectives

Agreement on a destination is necessary before we begin any journey. No social system can be efficient or successful until its objectives are defined. Again, the goals of the educational system closely resemble the goals of the system of health services. (Compare, for example, "Aims and Objectives", Chapter II, *Draft Report of the Commission on Post-Secondary Education in Ontario*, Queen's Printer, Toronto, 1972, and "Ends and Means", Chapter I, Report of the *Committee on the Healing Arts*, Volume I, Queen's Printer, Toronto, 1970.) The *goals* of health care can be stated quite simply:

- *Quality*: no system which diminishes quality of service can be consistent with the interests of either practitioners or the public.

- *Accessibility*: sufficient quantities of services, equitably distributed both geographically and socially, must be available so that access to essential services is available to all citizens.

- *Flexibility*: the rapidity of technological change re curative procedures, preventive methods, and organization of delivery patterns requires avoidance of monolithic-bureaucratic structures and emphasis on diversity and innovative *pluralism* to keep the system responsive to changing social needs.

- *Economy and Public Accountability*: since resources are scarce and the taxpayer must foot the bill, cost control and efficiency will remain important considerations; abuse of services by consumers and duplication or waste by practitioners and institutions must be inhibited.

- *Freedom*: our society places a heavy premium on individual liberty; within the necessary restraints of public safety and the acknowledgement of scarce resources, society will insist upon maximum freedom of choice for patients, and liberty of practitioners to choose the mode and location of their practice. Where public intervention is required to maintain quality, accessibility, or economy, coercion should be minimized and inducements or incentives created to achieve social objectives.

- *Coordination and Integration of Services*: in order to improve quality and accessibility of service, and to economize scarce resources (such as the TIME of physicians), as well as to facilitate improved understanding and cooperation between the various healing professions and disciplines, health services should be increasingly integrated into a true SYSTEM in which the various components

> are better coordinated. It will be essential also to integrate more closely with health services the related facilities of Welfare and Social Services, plus the facilities of Education which are important to public health instruction programs as well as the training of various practitioners.

It must be noted that these Aims and Objectives may on occasion be in conflict. Measures to increase Economy, for example, may not always be consistent with attempts to improve Quality or Accessibility. It remains the responsibility of government, through its various public planning agencies, to achieve a socially acceptable balance between competing objectives. This is a further reason why governments must be aware of, and respond to, the needs of consumers as expressed through orthodox and continuous channels of public representation and participation.

It must also be emphasized that Saskatchewan's health care system is relatively well off in terms of the Freedom of both patients and practitioners, the Quality and Quantity of practitioners and facilities of most (but not all) types, including hospital beds and adequate numbers of skilled, mobile, and highly remunerated physicians, together with a fairly flexible existing system facilitating change and public accountability.

Where shortcomings appear to exist, they are mainly in the areas of rural Accessibility to services, Coordination or Integration of certain services, and, in common with all other

jurisdictions in Canada, a growing concern over Economy and cost control. Sections of this paper below will touch upon these problems.

3. The Problem of Cost Control

High levels of health care are expensive; there are no magic formulae which will enable public authorities sharply to diminish the total quantity of resources devoted to health services. Indeed, a serious argument can be made for the proposition that Canada is at present devoting *too few* rather than too many resources to health, but distributing these resources inefficiently. (See J. T. McLeod, "Health, Wealth and Politics", in *Essays on the Left*: In Honour of T. C. Douglas, McClelland and Stewart, Toronto, 1971, pp. 92-94.)

However, health costs are rising, and cost control must remain a major concern of taxpayers and governments.

Fortunately, from many recent studies, royal commissions, task forces and reports in several jurisdictions, particularly from the *Task Force Reports on the Cost of Health Services in Canada* (Department of National Health and Welfare, Ottawa, November 1969), a consensus has emerged as to how best to restrain rising costs. There appear to be two primary avenues toward this goal.

First, in the most expensive single item in health costs, the hospital, economies may be effected by reducing hospital utilization rates. Both admission rates and average length of stay may be reduced. Comparisons with other nations suggest that Canada may have more hospital beds per capita than are required for optimum or efficient patient care, particularly in certain provinces. Because our health insurance programmes began with Hospital Insurance, and some people have tended to regard hospital care as "free", there may have been an understandable but uneconomic tendency to over-utilize expensive hospital facilities as substitutes for other forms of care such as nursing homes, clinics, ambulatory care, and home care. Fuller analysis of statistics relating to hospital utilization rates, and action on the results, may yield significant economies in health costs.

Second, it is possible to achieve a more efficient "mix" of healing skills, economizing one of the most expensive and valuable resources - physicians' time, relieving the physician of many burdensome tasks which plague him (and for which he is over-trained), and substituting less skilled (but more specialized paramedical or allied health personnel for the services of the M.D. This involves greater utilization of less expensive personnel such as nurse practitioners, optometrists, podiatrist-chiropodists, clinical psychologists, medical social workers and, in the foreseeable future, physician's associates, nurse practitioners, or practitioner's associates.

Such schemes point to the development of the "Health Team". Clearly the physician will be the leader of the Team. Here we are contemplating no direct assault on the physician's right to engage in "solo practice" if he so chooses; rather, we are considering the desirability of easing the existing burdens of paperwork and routine chores on the busy M.D., *supplementing* his services with those of a wide range of other practitioners. A reasonable rule of thumb may be: addition or substitution of less costly paramedical services for the expensive services of the physician, *not to supplant but to supplement*. Physicians' associates, for example, are not intended to replace the M.D., but to reduce his work load, free his time, and augment his capacity to serve patients. Increased utilization of various types of allied health personnel constitutes no more "threat" to the physician than does the medical student-interne.

The rationale for the expansion of various forms of multi-discipline health clinics is not only that clinics economize scarce medical time and skills, but also that they tend to *reduce* substantially the rate of *hospital admissions* (or increase the range and quality of ambulatory care), while at the same time making possible more comprehensive health care and expanding the emphasis on preventive medicine.

Undeniably, there may be risks involved in the utilization of some allied health personnel, but the poly-clinic or

multi-discipline health clinic minimizes and reduces such risks by ensuring that practitioners such as podiatrists, optometrists and chiropractors work in conjunction with, in close physical proximity with, and under the supervision of, fully qualified physicians who are the acknowledged leaders of the health care team and always available for consultation. There can be no doubt that these associated healing disciplines possess somewhat limited ability to perform the full differential diagnosis rendered by the physician, but already the public does have to resort to the skills of various allied health personnel in any case, and the public might better be protected by the closer integration of these allied practitioners under the supervision of the medical doctor in the setting of the community health poly-clinic.

Therefore, real economies, as well as increases in quality of care, may be effected by the expansion of various forms of group or poly-clinical practice, both by reducing hospital admission rates and by increasing the utilization of less costly personnel under conditions of enhanced public safety.

In fact, greater coordination or integration of health care through multi-discipline community clinics is likely to result in improved Quality of care, *but may yield only limited reductions of costs*, even though costs per unit of quality care may well decline. Any possible cost reduction

is useful and desirable, but the short run investment required to establish community health centres may not be recovered by increased efficiency until long-run factors come into play. It would be folly to believe that drastically slashed costs can be achieved overnight through creation of poly-clinics.

Drugs are an expensive item in health care, and significant economies may be achieved through substitution of less expensive generic products for brand-name drugs. But until drug costs are brought under public insurance programmes, particularly for chronic conditions, generic substitution will not diminish the charges on the public treasury except in hospitals, even though significant private economies may be effected for patients.

More effective preventive health programmes offer some hope for reduced costs in the longer run, particularly as they may be applied to younger school age children (eg. dental and optometrical services), but recent studies suggest that mass multi-phasic screening programmes may deliver increased quality of service only at increased cost. The high cost of case findings in many instances, the lack of treatment facilities for cases discovered, and the low or doubtful cost-effectiveness of some programmes when compared with alternative uses of the same personnel in public health units, all argue caution in the use of multi-phasic screening if

economy is the object. (Cf., *Task Force on Health Costs, op. cit.*, and P. Ruderman, "Task Force Reports on Health Costs: "A Review Article", *CJPH*, Vol. 61, July/August 1970, p.324.)

Thus, there is little reason to believe that major economies are likely to be effected in provincial health costs, *in the short run* through new patterns of practice or the creation of community health clinics. The three most costly elements of health expenditure are, first, hospitals, particularly in the larger urban hospitals, second, physicians' incomes, and third, pharmaceutical drugs. While these three vast and complicated subjects lie largely beyond the scope of the present study it seems clear that, if cost control is the principal *long-run* issue, Canada's provincial governments will have to formulate policies to achieve the following goals:

1. reduction of hospital utilization rates, and possibly reduction of the ratio of hospital beds per 1,000 of population, mainly through the substitution of ambulatory clinical facilities;

2. more formal means of carrying on tough-minded fee-structure negotiations with physicians; and

3. substitution of generic drugs for brand-name prescriptions through a carefully selected formulary of acceptable high quality drug products.

In the absence of such steps, it is difficult to imagine how rising health costs can be restrained.

4. Future Directions of Health Services

Recent studies in many North American jurisdictions, including several U.S. reports, the *Castonguay-Nepveu Report* in Quebec, the *Report of the Committee on the Healing Arts* in Ontario, and the *Task Force Report on the Cost of Health Services in Canada* seem to *converge* on a similar sketch of future patterns for health services delivery systems. With the shift from individual pre-payment to public insurance pre-payment schemes, a foundation has been laid for the following changes in health care delivery:

(1) The development of the various uncoordinated fragments into an integrated health care *system* will continue.

(2) The shift from a "Market economy" to a "political economy" of the health system will continue, with a growing emphasis on public regulation of the system. (See Part II, section 1, below.)

(3) Traditional medical practice is shifting -

a) from solo-practice to group practice or practice in ambulatory clinics,

b) from fee-for-service to salaried or capitation payment,

c) from individual practitioner care to *Team* care,

d) from hospital-based to clinically-based practice,

e) from under-servicing of remote and rural areas to better distribution of health care services,

f) toward increased use and coordination of allied health disciplines in an ambulatory clinical setting,

g) toward increased integration of mental and physical health care, with diminished emphasis on custodial mental health care, plus greater reliance on family physicians, clinical psychologists, and lay mental health workers to overcome the chronic shortage of psychiatrists.

(4) Traditional barriers between the various healing disciplines will be reduced; more disciplines will be brought into the health care Team.

(5) Combined university "Schools of Health Sciences" will break down the isolation of healing disciplines and play a growing role in sponsoring community education and community action in the health and social services fields.

(6) Technological innovation will accelerate

a) the development of new patterns of practice as well as new curative techniques,

b) the development and application of new hardware for information storage, retrieval and exchange, as well as diagnosis and treatment,

c) the development of better diagnostic practice to bring about improved preventive care, including genetic counselling (eg. re mongoloidism and cystic fibrosis).

(7) As a corollary, rapid technological change will underline present needs for more systematic methods of periodic retraining and continuing education of practitioners.

(8) Public information programmes will expand knowledge or preventive techniques, but also increase public awareness of the need for high quality of service.

(9) Increased public expectations re quality and distribution of services will result in more clamorous demands for public representation and participation in health care planning.

(10) Increased employment opportunities will be found in the health and social services field of the public sector.

(11) Rising costs will necessitate an expanded role for community self-help and voluntary organizations at the local level.

(12) Health, Education, and Welfare services will be recognized as a related continuum of social services requiring greater coordination and integration.

(Compare, for example, Committee to Study Education for Health Services, "A New Health School Model", York University Report, July 1971; or D. Rutstein, *The Coming Revolution in Medicine*, Harvard University Press, Cambridge, Mass., 1967.)

Prediction is easy, and accomplishment difficult, but these do appear to be the most likely extrapolations of present trends which indicate the future directions of health care patterns and policies. Reasonable men will design their strategies in accordance with future expectations.

Anticipations of future trends make it imperative for practitioners, governments, and citizens to prepare themselves

for sweeping changes in the organization of social services through new patterns of health care.

> "In all countries, regardless of differing economic or political systems, medical care is changing from a private relationship between two individuals into a medico-social institution or, more precisely, a great network of specialized institutions which make it possible to provide better care to more people than ever before. This is the over-riding fact of twentieth century medical care - as it is of education, industry, and government. In medical care, as in other spheres of activity, the scientific and technological revolutions and their far-flung implications *have not yet been organizationally assimilated.*" (H. Somers and A. Somers, *Doctors, Patients, and Health Insurance*, Brookings Institute, Washington, D.C., 1961, p. 106, italics added.)

While considering the future, it would be impossible to exaggerate the importance of integrating not only the various healing disciplines, but also health services together with the other social services. Certainly health care services are part of the wider strategy for redistributing resources to the poorer and more vulnerable sections of the community. But it is increasingly doubtful whether health services alone, without support from other welfare and social development services, can be an adequate instrument for the equitable distribution of public resources.

Rudolph Klein is only one of many who argue that the longer British experience with a welfare state "...suggests that *developing the social services* (public housing for the

aged, public nurses and home helpers to visit the sick and infirm in their own homes) *may be the only way of preventing an ever-rising demand on the more expensive health services proper*. One of the main aims for the future will have to be to devise policies which will support the organic, social network of health care... To the extent that a health service is asked to play a more general socially supportive function, it is being cast for a role where the medical profession's traditions are a major obstacle, and where the skills involved can often be supplied at a lower cost by others. If this view is correct, then *the main objective for the future should be to contain rather than to expand expenditure on the health services as such, but to integrate them more closely with, and divert any extra resources to, the socially supportive services*. This, at any rate, seems to be the direction in which Britain is now moving...." (R. Klein "The Political Economy of National Health", *The Public Interest*, No. 26, Winter 1972, pp. 124-5, italics added.)

An awareness of the growing inter-relationship of health and social services policy is growing in many jurisdictions including Canada. This important point was underlined by the publication in August, 1972, of the federal *Report of the Community Health Centre Project* - The Hastings Report, which has already been endorsed "in principle" by Canada's Ministers

of Health at their conference of May, 1973. This Report is almost certain to be regarded by future historians as a major landmark of social policy in Canada, comparable to the Thompson Committee Report on Medicare in Saskatchewan, 1961, and the Report of the Royal Commission on Health Services in Canada (Hall Commission), 1964. The main thrust of the Hastings Report is toward the creation of ambulatory health care by *teams* of health personnel as a substitute for more costly hospital care. (Several aspects of this impressive Report will be cited below.) The Hastings Committee acknowledges the necessity of viewing the provision of health services within the broader context of general public social services.

> It has been recognized for some time that many health problems have a psycho-social and economic component.... Now, however, it has become clear that more and more of the problems which affect individuals and families cannot be neatly classified as health, social, economic, legal, education or housing problems. Among examples of this sort of personal and societal "disease" are mental illness, drug and alcohol dependency, delinquency, alienation between parents and children, personal violence and violence against society's established institutions, and many problems of the aged. Because the number and nature of such problems will undoubtedly increase in the future, community health centres must have practical working relationships with social services and with other community resources.

It is also worth emphasizing that on the issue of health costs and particularly hospital costs, referred to in the previous section of this paper, the Hastings Report sees community health centres and multi-discipline team practice as a less expensive substitute for hospital care in the long run.

> ...The chief means of controlling costs within the hospital sector is to be found in a reduction in the present acute bed/population ratio and a consequent reduction of in-patient services and facilities. Increased emphasis on alternative forms of care, such as extended care facilities, home care programmes and community health centres, are seen as ways of achieving this goal. However, it must be emphasized that any real savings from a reduction in hospital in-patient utilization can only result if alternative forms of care not only replace some proportion of care presently provided on an in-patient basis, but also if there is a co-incident reduction of in-patient facilities.

These considerations underline the necessity of viewing health services in the broadest possible context of public services generally if economies and innovative reforms of institutions are to be achieved.

5. Planning Necessary Inter-Relations of the Planning Framework

Health planning, to be effective, must be related to the general planning framework of government. Health services policies must be related:

First, to the over-all economic strategy of the government, and

Second, to the associated social services of Welfare and Education.

Planning requires the best possible information inputs if rational policy outputs are to be attained, and in a province such as ours the most crucial information concerns POPULATION: how many people, located where? Without this basic information, any and all planning is seriously handicapped.

Every policy and plan would seem to hinge on the population question, or, to put it another way, on the fundamental economic development plan, the general industrial development strategy of the government. Clearly it would be foolish to plan improved health services for villages and farm populations destined to disappear due to market forces and/or the general economic development strategy. Thus, the root question is: HOW MANY PEOPLE? WHERE? Everything depends upon that.

Therefore, in order to relate health planning to over-all government policies, it may be helpful to think of provincial government activities under two broad headings:

(1) the *Allocation of Resources* and general administrative function, including the Population-Economic Development strategy;

(2) the *Operational* or delivery of *Services* function, the provision of public services in the field, including Health, Education, Social Services, and Agriculture.

This simple division of provincial government functions may assist us in thinking about basic questions relating to Centralization and Decentralization.

It is evident that the first or *Allocation of Resources* function must be *Centralized*; otherwise, (a) the provincial government would be weak, would abdicate basic responsibility; (b) the people would be left vulnerable or helpless in the face of raw market forces and the manipulation of the economy by autonomous national and multi-national commercial corporations.

It seems equally apparent that the second or *Operational-Service* function must be *Decentralized*; otherwise, (a) public services may be encased in giant, monolithic departmental structures, insufficiently flexible, and too far removed from the individual citizen; (b) citizens and local communities may have little or no direct opportunity to make their needs known, or to participate in the decision-making aspects of those functions of government which touch the individual most closely.

At present, the most fashionable planning device in many jurisdictions (although the Americans now appear to be

backing away from it) is Cost-Benefit Analysis or *PPB* (planning-programming-budgeting). This is a very useful tool for comparing alternative expenditure patterns *within departments*, but it is of sharply limited utility for evaluating alternative expenditures *between departments*.

It is not yet possible for social scientists to measure with any degree of precision the social costs or the social benefits of public investment decisions between, say, health and housing, or roads and education. We lack the necessary numbers (statistics) and the conceptual tools. We do not have an adequate general theory of optimal allocation for public resources, or satisfactory criteria for making inter-departmental choices between alternative expenditures.

Therefore, while government must make the tough decisions concerning priorities and the allocation of public resources, cabinets are still doomed to fly mainly by the seats of their political pants. Some of the gut information they require is denied them. Planning and policy formulation remains the most onerous task of government.

Here again, government *planners need more and better information* on which to base rational decisions; hence the growing importance of decentralized schemes for the Operational-Service function in which the people can participate. Popular participation in the planning process at various levels can

enable local communities and citizens to influence decision-making, express their needs and desires, and better *inform* government as to where change is required. The people cannot plan directly or dictate to cabinet, but the people can provide improved information on which the cabinet can base its deliberations and planning processes. When we are designing new shoes, it is necessary to know where the old boots pinch.

6. Current Planning in Manitoba: THE "STAY OPTION"

The thinking of an administration in a neighbouring province, longer in power than the Saskatchewan administration, seems sufficiently interesting and important to merit special mention in this Background Paper.

The Manitoba government appears ready to move toward regionalization and decentralization. Apparently Manitoba intends to divide that province into *three principal regions*: 1) Winnipeg 2) the North and 3) the remainder of rural Manitoba. Each region will include several local units or districts, brought together for planning purposes under a regional board or council with elected membership.

In each district there seems likely to emerge a Health and Welfare Centre, a community health clinic similar to that urged in the federal Hastings Report, and including welfare or social service personnel. Clearly it is at the local or district

level that the main thrust of health policy will be concentrated in the short run.

The "*Stay Option*" policy for rural population retention appears to be the most interesting aspect of the plan. It includes two main thrusts:

(1) *Improved public services* at the local level through highly decentralized administration,

(2) *Increased rural incomes* and farm prosperity through

a) support prices for farm products, by means of subsidies paid on a discriminatory basis only up to certain maximum acreages and incomes, in the hope of assisting the smaller farm,

b) redistribution of land through land bank policies,

c) lowering the costs of production, or altering the "conditions of production", through use of cooperative farming techniques, machinery co-ops, effecting economies of scale, and using the Matador co-op farm model,

d) encouraging diversification and specialization of farm production,

e) using economic planning on a regional basis to increase non-farm *alternative employment opportunities*.

Manitoba planning officials admit that they are pessimistic concerning non-farm employment possibilities, but believe there may be some scope for the utilization of provincial powers to induce major corporations, extracting and exporting

raw materials, to process more products within the province and to create more jobs. Expanded public ownership and Crown Corporation activity is being contemplated. In the Saskatchewan context, this might mean (for example) a commercial venture jointly owned by the provincial government and a Japanese corporation to refine and process potash within the province, and to market it directly, without the interposing of an American corporation. (Why Japanese capitalists are prepared to act differently than U.S. capatalists remains to be discovered.)

However, the bare outlines of this strategy indicate that the Manitoba government has placed a high priority on the Stay Option to hold population, and a scheme of decentralized regionalization to improve public services at the local level with increased popular participation. Clearly Manitoba intends to involve local people in a scheme of decentralized democratic planning. (See "Guidelines for the '70's," Queen's Printer, Manitoba, 1973.)

7. The Basic Design

So far we have reviewed several elementary but necessary background considerations which may help to spell out the nature of the assumptions implicit in this study. The

limitations of this Introductory section are apparent, but it has seemed desirable to make explicit the assumptions and the general conception of the policy framework which underlies the Parts that follow.

Emphasis has been laid upon the necessity of fitting Health policy into a broader framework of economic development and social services planning. The importance of integrating health and welfare policies has been stressed. Broad hints have been offered, and groundwork laid, for the consideration of policies which will permit increased popular participation in the formulation and implementation of social development plans. Care has been taken to avoid thinking about health planning in a vacuum, as though the problems of health care were entirely unique or had an existence independent of other public concerns.

However, in the following pages it will become clear that *no simple merger of the Health and Social Services departments is proposed.* Already the separate departments of Health and Social Services are large and unwieldy; there are obvious obstacles to their merger, and attractive alternatives to any crude merger scheme do exist.

In what follows, it will be suggested that if Health and Social Services policies are coordinated at the top or cabinet-policy level, and if field services are integrated at the

bottom or community-grassroots level, no major problems need emerge which would require melding of the two departments.

The sections of this paper below will review the rationale for increased public participation in the formulation of health policy, problems of regulation of the health professions, and issues related to the decentralization of health services and planning.

PART II

CONSUMER PARTICIPATION

II. CONSUMER PARTICIPATION

1. The Present System and the Position of the Consumer

At present it is painfully apparent that the role of the individual in the health care system is very much restricted. The individual practitioner must work within the structured framework laid down by his profession, his hospital, and by government legislation and regulation. The individual patient or consumer is even more confined and restricted. On the one hand, the consumer may be confused and frustrated by the sheer size and complexity of the health care system: the forms he must fill in, the contradictory advice received from various practitioners, the impersonality of the large hospital, and the vast bureaucracy of the Department of Public Health. On the other hand, the consumer's freedom of choice may be limited in that he often may choose only between the one doctor available in his community, a long and expensive trip to a major urban centre, or no doctor at all.

In general there are only three things most consumers can do: they can do what their physicians tell them; they can wait, in hospital waiting rooms, or in physicians' offices; they can pay, bearing the financial burden through premiums and through general taxation. To take orders, to wait, and to pay; these are not very exhilerating functions.

In trying to sort out and expand his role, the individual citizen has great difficulty in understanding the system. From the textbooks, he will find that basically *there are only two patterns or models for the allocation of scarce resources* in our society. Neither model is to be found in its pure form, and there are, of course, various "mixes" to be observed, but at root we have only two primary choices. *First*, there is the Market Economy model in which the forces of supply and demand determine prices, and prices influence the individual's choice of what to buy. *Second*, there is the Political Economy model in which resources are allocated by government decisions. Either type of system is fundamentally a device for distributing or rationing scarce resources. The crucial question is, who makes the decisions about who gets what resources? All other questions are secondary, or mere housekeeping.

It is axiomatic that any economic system or model is expected to serve the consumers. Note that both the Market Economy and the Political Economy models contain important safeguards to protect the interests of the individual consumer. Under conditions of market pricing, competition keeps consumer choice wide and prices low; individuals make up their own minds what to buy, and thus we speak of "consumer sovereignty" in the marketplace. Similarly, in a Political Economy the

planners and the government decision-makers must face elections; if we don't like the results we can "throw the rascals out" through the exercise of political sovereignty at the ballot box. Under either model, consumers have significant influence and means of protecting themselves.

However, the fatal flaw in this elementary analysis is that in the field of health services, resources are *not* allocated primarily through *either* a market economy *or* a political economy. To a high degree, the principal power, the determination of who gets what, rests mainly with the professions, particularly the medical profession.

It is true that physicians and other health practitioners fear the increasing power of government, and not without some reason. It is true that government uses the taxpayer's money to finance the system, and since all democratic governments must be held accountable for public monies spent, the government must maintain certain careful controls over health expenditures. However, at present most governments simply use and supervise insurance arrangements to pay for existing patterns of health service, and find it very difficult to innovate or to change those patterns of care.

This point is obvious and fundamental, but it is often overlooked. In assuming the power to pay the bills for health

services through public insurance plans, government has not necessarily assumed effective control over, or leadership in, the health system. Government has merely agreed to pay the bills, but it may have put the financial cart before an extremely unsatisfactory horse. The public is now paying, at a rising rate of cost, for a health care system characterized by social and geographical maldistribution of services, scarcity of some types of practitioners, inefficient underutilization of various allied health personnel, frequent conflict between medical and non-medical practitioners, obsolete patterns of practice, and apparent over-utilization of hospitals. By merely paying for what exists, there is real danger that public health insurance may have "locked us in" to perpetuating inefficient and outmoded patterns of service.

Having agreed to pay, government must now be prepared to lead, to reorganize, and to innovate if patterns of health care are to be improved and costs controlled. But it is by no means easy for any government quickly to overcome the restraints of institutional rigidities, habits, traditions, and both public and professional resistance to change.

It is important to recognize the central position enjoyed by the medical profession and the extent to which it controls the health system. Through their professional organizations, physicians control licencing, discipline, and

quality of service; in most provinces until recently, they have set their own fees and remuneration unilaterally; they decide where they will or will not locate geographically; directly or indirectly they determine the roles and scope of practice of non-medical allied health personnel; they determine hospital admissions and largely control hospitals. Thus, the *professional power of organized medicine is enormous*. In great measure, physicians control both the quality of care and the major costs of health services; generally they have determined the shape of the delivery system and the basic organization of health care.

Faced with this considerable professional power, it is scarcely surprising that individuals often charge that *the health system is professionally dominated and producer-oriented rather than consumer-oriented or dominated by government*. This is why the charge is often heard that in no other major sector of our society is the consumer more mute and powerless.

There is a broad general problem here, by no means peculiar to medicine alone. Since we live in an increasingly "technological society", and since technology is controlled essentially by the professions, we are all dependent upon, and have a growing public stake in, the professions: the engineers, lawyers, scientists, and professors, as well as the physicians.

To some degree, all professions are powerful. By their very nature, they tend to be somewhat introverted, highly restrictive, and for the most part they are organized as monopolies. The essential principle of licensing, after all, is to confer a monopoly on those licensed. Because we know how the public feels about business monopolies, we should scarcely be surprised at the mounting public reaction to professional monopolies.

It seems inevitable that the private monopolistic power of all professions increasingly will come under public scrutiny and public regulation. The day of absolute professional "autonomy" is clearly over; that writing is already on the wall for all professions to read. For the immediate future, the real question is not how to preserve "absolute" professional autonomy, but how to effect public regulation and public accountability of the professions without crushing professional autonomy completely, and without diminishing professional standards of quality.

At any rate, it is clear that most jurisdictions in the Western world, even the U.S., are moving steadily toward a Political Economy model for health services. It is also clear that public concern over rising costs and the shortcomings of the system is creating a growing demand for increased consumer participation. As we move further toward the Political

Economy model, it is doubtful whether the growing power of government can be checked adequately by the simple device of democratic elections. Governments may be turned out of office only infrequently, and they may receive (or be deprived of) votes on the basis of other issues entirely unrelated to health care. The ballot box is important, but it does not provide sufficient safeguards for vital consumer interests.

Moreover, we must note that the trend toward greater politicization of health care may or may not be neutral as between social groups or classes. Depending upon the political complexion, ideology, or simple inertia of the party in power, any Political Economy of expenditures and social services may be weighted more in favour of urban or rural populations, rich or poor, advantaged or disadvantaged groups in society. In order to redress the normal imbalance in the provision of public services enjoyed by urban and relatively affluent groups, presumably it is necessary to adjust the political economy of health through deliberate government policies aimed at improving the quantity and quality of services available to rural, disadvantaged and "have-not" groups, and to assist these people in securing a greater and more direct voice in influencing public policy.

2. Consumer Participation - WHY?

The preceding sketch has indicated some of the underlying reasons for the present frustrations of consumers, and suggested why consumer participation is desirable. We must now indicate more precisely the potential advantages to be gained through increased consumer participation.

First, we might not ask "why?", but rather "why *not* consumer participation?" The whole point of any economic or political system, after all, is the maximum satisfaction of public or consumer demands. If that elementary purpose is lost sight of under any system, the whole of society is in trouble.

Second, contemporary North American society is being swept by demands for "participatory democracy". To a student of political theory, these demands seem unfortunate and redundant, not because they are unimportant, but because they reveal sad failures of democratic practice; in fact, the word "*democracy*" means and implies *participation*. Much of western democratic practice has been built upon the foundation of direct involvement of the people. In general, democrats believe that popular participation is good, and authoritarian paternalism is bad. Massive bureaucratic structures tend to alienate the people, restrict democracy, and inhibit popular participation.

Third, cabinet ministers as well as individual citizens realize that giant service departments of government face serious administrative problems. Administrators often display an understandable tendency to do what is familiar, convenient, or administratively simple rather than what is desired by the people. *Bureaucracies often tend toward inertia and inflexibility*, which in turn increase the frustration and alienation of citizens. Consumer participation may help to overcome these regrettable tendencies.

Fourth, in order to be responsive to the people they serve, governments require more and better *information* for purposes of rational planning. Citizen participation may help to improve both the quality and the quantity of information upon which government planners make their difficult decisions. Means must be found to enable ordinary citizens to inform government as to what the people want, what their problems are, and what the specific shortcomings of public policy may be.

Fifth, consumer participation facilitates the levelling of *complaints* at government. All individuals have many complaints which they would like to throw at both public and private-commercial agencies; the problem which causes principal frustration is that people, particularly when faced by public bureaucratic structures, do not know where or how

to register their complaints. The familiar taunt that "you can't fight city hall" inhibits and diminishes democracy. If quality and accessibility to service are important goals of the health care system, complaints must be ventilated and taken seriously. It is always necessary for politicians and administrators to be reminded where the shoe pinches. Moreover, when citizens have only the ballot box as their main vehicle for complaint, governments naturally desire to learn of serious complaints long before election day. It is in the best interest of government, as well as of consumers, to facilitate the process of ventilating and redressing grievances prior to general elections. For governments, failure to listen means loss of votes. For consumers, absence of orthodox grievance procedures means frustration and bitterness.

Sixth, increased education, leisure, and affluence have made consumers much *more sophisticated* than ever before. Consumers are now much better informed than in the past, and it is apparent that the public displays rising expectations for higher levels of services and rising expectations could lead to unrealistic hopes for the achievement of a health Utopia overnight, but increased participation by consumers and greater involvement of the public in health care may bring about the realization that perfect health cannot be provided on a silver platter either by physicians or by

governments. Involved consumers will have greater realization of problems, and understand that resources are scarce and that abuse of health or other social services creates waste and rising costs. Involvement of citizens in health services implies increased awareness and growing education of consumers, even in matters of cost restraint. Through participation, consumers can learn. It would be silly to downgrade the potential contribution of individual citizens; after all, it was essentially the pressure of consumers and voters which was responsible in Canada for the rapid spread of hospital and health insurance programmes. What better testimonial could there be for consumer involvement?

Seventh, the sophisticated *technological complexity* of modern health care is often intimidating to individuals. Many people feel baffled and powerless, mere pawns in the hands of impersonal technicians. These feelings of alienation reinforce the demands of ordinary citizens for some degree of representation and participation in the decision-making processes of the systems which affect them most directly.

Again, the recently published Hastings Report underlines the necessity of providing for increased public involvement on the part of ordinary laymen and the community. Arguing that the health care system must be "responsive to the health needs of people", the Hastings Report states:

> Responsiveness may be further assured by people actively involving themselves in programmes of health promotion and health maintenance, assuming a wider responsibility for their own health and that of their families, and using services in an as intelligent and effective way as possible. Responsiveness may be promoted by involving the community in policy-making, priority-setting and decision-making through various forms of boards, councils and advisory or grievance bodies. It may be helped by the use of "lay" health workers or "members relations" personnel serving as intermediaries between the public and the health services; in other words, by assuring effective "two-way" communication.

3. A Digression on Radical Theory

Many individuals feel increasingly alienated from contemporary mass technocratic society. With the exception of the Hastings Report, these feelings of profound alienation do not seem adequately understood or reflected in most recent studies of health services.

Certainly there is great merit in many health care studies such as the federal Task Force Report on Health Costs, The Report of the Ontario Committee on The Healing Arts, and the Castonguay Report of Quebec, but *all of these studies seem obsessed by a somewhat narrow-minded view of "efficiency" and "rationalizing" the system*. There remains something slick, impersonal and inhuman about some aspects of these reports. With their emphasis upon coordination, integration, rationalization, economizing, and technocratic efficiency to

bring about a sleek and coldly functional apparatus for health care delivery, the authors of these reports may have neglected the essential human element. In some ways their recommendations seem *at variance with the radical critique of contemporary society*. Systematization and rationalization are desirable, but they are not ends in themselves. Technocrats do not have all of the answers, and the most sophisticated technological system will fail if it does not take into account the personal needs of individuals.

The patient, when afflicted by illness, is not impressed by computers or technocratic schemes. He requires intimate, time consuming, personal care and human involvement. Both doctors and patients would agree that the quality and satisfaction of medical service depends in large degree upon the time and care that can be devoted to the unique needs of the individual patient. The most sophisticated schemes of planners and "experts" may founder if the intimate personal needs of distressed individuals are neglected. At this point, *the apprehensions of many physicians are at one with the criticisms of radical theorists* and activists who fear the unrestrained application of technological systems analysis.

It is fashionable to observe that modern medicine exhibits a fragmented system, a non-system, or an obsolete "cottage industry". There is considerable truth to these

charges, but it is significant that both conservative physicians and political radicals share many fundamental perceptions and values. Both are haunted by the spectre of mindless and inhumane technological determinism.

A brief summary of contemporary radical thought may be illuminating at this point. If liberalism and the Welfare State have concentrated upon more efficient distribution of goods and services, radical thought has focussed on *why* goods are produced, *how* they are produced, and the effect of their production of the quality of life of the consumers. Looking at industrial, technocratic society, radicals acknowledge efficiency but lament de-personalization; they see man as rich in goods but poor in spirit. They see the common illness of Western man as *alienation*. Almost all contemporary radical thinkers reject centralization, fear unchallenged technology, and view mankind as having bartered its freedom for excessively systematized efficiency. (Compare M. J. Halberstam, "Liberal Thought, Radical Theory and Medical Practice", in *The New England Journal of Medicine*, Vol. 284, No. 21, May 27, 1971, p. 1180.)

For better perspective on this dilemma, we might contrast the orthodox technocratic view with that of radical writers. The views of those who stress organizational efficiency are typified in the following quotation:

> In our interdependent society...I suspect that those individuals will feel independent and self-confident who have learned how to survive and grow within large-scale organizations, not how to escape into the interstices between them...It is precisely by the development of his administrative skills that Man preserves and extends his freedom. The complexity of modern society and the omnipresence of large-scale organizations not only provide an opportunity for the fullest development of the responsible self; they actually place a premium on the exercise of a greater measure of personal responsibility by more people than ever before. (Harlan Cleveland, Dean, Maxwell Business School, Syracuse University, 1958; quoted in Somers and Somers, *op.cit.*, p. 106)

To the contemporary radical, this typical view appears as the kind of naive nonsense which increases industrial impersonalization and alienation.

The rejection of this view by radicals can be seen in the work of Herbert *Marcuse* who argues that increasing industrialization is inseparable from rigid bureaucratic control; Marcuse advocates smaller units of production and increased democratic control of mass systems through extreme decentralization. Similarly, J. Ellul argues that man is now the prisoner rather than the beneficiary of technology (see *The Technological Society*, 1964).

Many other examples of current, radical thinking can be cited. Paul *Goodman* (in *Growing up Absurd*, and in *People or Personnel*) has emphasized the diminished power of individuals over their own immediate surroundings, and argued for decentralization. Goodman urges that whenever feasible,

and even at the risk of some apparent inefficiency, society's institutions must be made smaller and less centralized. He is explicit about medicine: "The units of human service such as school classes or the clientele of a physician ought to be made smaller to avoid the creation of masses; mass teaching, mass medicine, mass psychotherapy, mass politics."

Theodore *Roszak*, in *The Making of a Counter-Culture*, 1969, has identified and sympathetically summarized several of the elements within today's radical "counter-culture". Like Marcuse and Goodman, Roszak makes a rational appeal for an infusion of "irrationality" into Western society, and attacks the rule of bigness and technology, advocating extreme decentralization and re-personalization of services.

In short, there are other important humane goals and values apart from technological or systematic efficiency. It is noteworthy that these writers, like the Canadian Wafflers, agree on a general advocacy of "power to the people" and extreme decentralization of essential public services. Participatory democracy, like motherhood, may have become a cliché, but it may be a cliché because it contains an important grain of relevance and truth.

We would do well to bear in mind that sheer physical size or economic efficiency, whether in large hospitals or in large multi-discipline community health clinics, offer little

hope of salvation for individuals. The *contradiction* between the radical analysis of contemporary society and currently accepted proposals for reform of health services is important. Changes in the delivery system which result in increased de-personalization may result in economies but not in quality of care or human satisfaction. It should be obvious that impersonal or dehumanized services, no matter how "efficient", are in large part what is bothering contemporary radicals. "It should be conceded that technology is not *per se* desirable, and no longer - if we remember the large number of talented young people who have totally rejected it - inevitable." (Halberstam, *op. cit.*, p. 1184.)

4. Consumer Participation: WHO?

The nub of the argument in the preceding section has been that just as *laissez-faire* has become a dangerous and outworn ideology, the unthinking acceptance of a *laissez innover* philosophy, or the "technological imperative", also contains serious dangers and contradictions with democracy. *Laissez innover* may expand the power of the mandarins, bureaucrats and technocrats unless it is offset by deliberate policies of decentralization which facilitate the participation of local communities and individuals, both producers and consumers.

Who is the consumer? He is everyman, every citizen. There is no one in our society to whom health services are irrelevant, including of course the practitioners of medicine and their families: all are consumers. Therefore, it seems preferable to talk of "public participation".

Participation is a two-way street. Even granted the considerable power of professional organizations, practitioners as well as patients ought to be involved in the planning and policy implementation processes. Unless practitioners understand the direction of changes and are involved in those changes, they will tend to resist and inhibit reform; practitioners can become bitter and alienated even more rapidly than consumers can. The continuing possibility of misunderstanding and mistrust between politicians and professionals in Saskatchewan or in any jurisdiction makes it imperative that these barriers be removed wherever possible by increased involvement and participation of practitioners in policy formulation.

It then becomes a delicate question as to how best to combine and balance producer and consumer interests on representative bodies.

The most obvious answer would be to represent professionals and consumers equally on advisory bodies on a fifty-fifty basis, but this might also be a disastrous answer.

Such a crude half and half arrangement might tend to promote confrontations and/or log-jam tie votes if either group attempted to impose its views on the other. Every effort should be made to avoid situations of confrontation. "The solution lies in building a creative partnership between consumers and providers rather than establishing the supremacy of either." (*Report of the National Advisory Commission on Health Manpower*, Washington, D.C., U.S.A., 1967, Vol. II, p.13.)

Any crude half and half arrangement would also neglect the useful contributions of various representatives of *paramedical* or allied health personnel. Since a major planning objective is to increase utilization of paramedical skills, and since greater coordination of a mix of various practitioners is also desirable to improve integration of the system, it will be advantageous to provide significant representation of allied health personnel in addition to consumers and medical practitioners.

The potential role of this third group should not be underestimated. Paramedical personnel have the unique distinction of being at once "consumers" of medical services, practitioners of health care, aware of (but not necessarily subservient to) medical views, and more knowledgeable than most laymen concerning the complexities of health services. They

may serve as an extremely useful "buffer" between physicians and consumers. Then too, close collaboration between medical and non-medical practitioners on planning bodies may assist both groups toward greater understanding of each other, and help to break down existing inter-professional barriers.

Therefore, it is proposed that representation of both producers and consumers on various advisory and planning bodies be provided for in three equal parts: 1, physicians; 2, allied health personnel; and 3, laymen. (In effect, this is the allocation of representation on the Ontario Council of Health which seems to be functioning smoothly.)

Next, we must consider how to select suitable representatives of that largest and most amorphous group, laymen or "the public". Naturally, we do not want to select just any uninformed persons at random. People must be chosen who are already informed about, or interested and capable of becoming informed about, the problems of health care.

Stupidity is invincible, but ignorance can be overcome; ignorance can be overcome a) through experience and b) through the provision of background educational seminars designed to acquaint both consumer and producer representatives with the present policies of government and with general problems of health planning. Through the use of special training programmes,reading courses, conferences, and background

seminars, it should be possible to involve and inform a large cross-section of public representatives quite quickly. Numerous citizens from many walks of life are already quite well informed concerning health policy problems. Whether they are drawn from existing boards of hospitals trustees, user's committees of clinics, co-ops, farm associations, labour unions, or universities, many citizens can be found who are already surprisingly well informed. Experience, involvement, and background seminars will quickly make them much more so.

However, we should not regard the public as a single mass. It is important to distinguish at least *two major categories among laymen: first*, the relatively affluent and middle classes, who are already well represented on many existing social institutions, and *second*, the disadvantaged. It is important to recall that most existing social institutions reflect strong class biases, over-representing the comfortable middle class. On the other hand, the relatively neglected and disadvantaged groups among society find it much harder to achieve a voice in public policy; these groups include the poor, the Indians and Metis, other minority groups, those on welfare, and the voiceless many who do not normally participate in society's affairs. Special care must be taken to represent these disadvantaged people. To this end, particular suggestions will be made in the following section.

5. Consumer Participation - HOW?

In this section we propose to consider public participation at three levels:

- At the bottom, or local community level;
- In the middle, at the district or regional level;
- At the top, or provincial government level.

(a) *At the local community or grass-roots bottom level*, assuming the gradual development of health and social service centres as described in The Hastings Report and in Part IV of this paper, it will be desirable to involve local people at the level closest to their own needs. Public participation should be invited through the creation of boards or committees to plan and supervise the administration of local health and social service centres. These boards or committees should represent a) professional practitioners, b) allied disciplines and practitioners including public health personnel and public health nurses, and c) laymen. The component of laymen should include both local nominees appointed by existing community institutions (municipalities, hospital boards, etc.) and elected representatives of "user's committees", including representatives of disadvantaged groups.

Health and Social Services Centres should be regarded as the basic "cells" of Districts or Units of any future

Regional system. These community centres should have provincially appointed administrators responsible to boards or councils as sketched above. Each council should encourage the creation of "user's committees" which would provide elected representation for people on welfare and other disadvantaged groups as a significant component of the lay membership. Representation for "user's groups" is particularly important because municipal and other middle class appointees often tend to be somewhat punitive in their approach to welfare payments and distribution of public resources. This factor reinforces the importance of provincial Guidelines within which local Health and Social Service Centres or Community Development Centres should carry on their work.

Because of the importance of decentralizing operational or field service functions, the most essential part of the integration of health and welfare services must take place at the grass-roots or local level, through the Community Development Centres. In these Centres, public health nurses, social workers and other related public service personnel should collaborate to assist general community development.

(b) *At the middle or Regional level*, there might gradually emerge Regional Councils (as described in Part IV) through which the activities of district Centres may be coordinated.

At the regional level, once again public participation might consist of representation for the three principal groups: professional practitioners, allied services practitioners, and lay representatives. However, at this level lay representatives might well predominate. The composition of lay representation should include both elected and appointed representatives of the public. At the initial stages of the scheme, and to maintain a strong provincial presence from the outset, the provincial government might appoint members of Regional Councils from lists of nominees selected by district practitioners and existing local institutions, while only a small minority of the public representation might be elected directly. In this manner the provincial government would be assured of strong initial appointees. Later, as popular pressure for change develops spontaneously, the province would have ample room to manoeuver and withdraw its appointees in favour of growing elected representation.

(c) The emphasis placed here upon local participation at the bottom or community level implies that local Community Development Centres must receive strong support from the top or provincial government levels as elaborated in Part IV below. *At the top*, there are several methods by which public participation in the system may be increased.

First, significant lay representation might be included on professional licencing bodies and Colleges of Practice as described in Part III of this paper.

Second, a provincial Ombudsman might be appointed to receive, investigate, and recommend action upon complaints received from members of the public. This Ombudsman or Social Services Commissioner might specialize in and deal with complaints from both consumers and practitioners involved in the social service system including health, welfare, education, and agricultural services.

Third, if we recall our initial division of provincial government services into 1) allocation of resources functions and 2) operational or service functions, increased use might well be made of the existing but hitherto neglected talents of back-bench political representatives: the MLAs. These elected representatives in the legislature constitute a major but unexploited resource for the improvement of the public service system; anything which can be done to expand their now limited functions would be a plus for parliamentary democracy. MLAs from both sides of the House might be constituted as a Standing Committee on Social Services to review the adequacy of, and discuss complaints concerning, the social services of Health, Welfare, Education and Agriculture. By explaining and interpreting to the public a new decentralized

social service system, by their critical scrutiny of the system, and by their "relentless encouragement" toward efficiency and innovation, MLAs might perform a major role in improving the operational services system and explaining it to the public.

Fourth, and perhaps most important, public participation at the top or provincial government level should be increased through the creation of an *advisory council*, including lay representatives, whose functions (see Part IV below) would be principally to review, and to make policy recommendations on, health programmes.

However, before examining the means and methods of public participation in the formulation of health policy generally, it is necessary to review the central role of the health professions in the delivery system and the possibilities of greater public influence being exerted on the regulation of the professions. These questions are explored in Part III.

PART III

PUBLIC REGULATION OF THE PROFESSIONS

A profession is an organized group of individuals providing a specific service to society, a service based upon a body of knowledge which can be applied to human needs and to a social purpose. That is, the profession does not possess knowledge or skill for its own sake, but for the purpose of applying it to society's needs. Thus a profession fulfills a public and social function. In the case of the profession of medicine, for example, the purpose of the physicians' knowledge is to promote the health and well being of individuals and of society.

Occupational skill groups or callings designated as "professions" usually share certain common characteristics: practitioners are highly educated and share a common body of knowledge; the service provided is one in which more than mere technical competence is required for the service of clients and for the protection of the public, that is, standards of ethical conduct must prevail; considerable public confidence is reposed in the practitioner, requiring that he does not exploit the intimate details of his client's life and affairs which are divulged to him; public confidence in the professional practitioner is of the essence. To be effective, the nature of the service provided requires confidence of two kinds - the personal confidence of the client in

in the technical competence of the practitioner, and the confidence of the public at large in the integrity and ethical conduct of the profession as a whole.

In order to sustain the confidence of the public, professions must see to it that their members achieve and maintain high quality standards and competence. Some form of specific regulation is required to maintain such standards. Thus, a professional service activity demands a certain form of collective control. To make that control coherent, effective and continuous, the collective regulatory action requires the support of law. Professional law thus has a strictly functional purpose: to maintain standards and to protect the public interest. Protection of the public is the sole social utility and the sole purpose of professional law. (Compare: *Royal Commission Inquiry into Civil Liberties*, McRuer Report, No. I, Vol. 3, p. 1162; also *Report of the Commission of Inquiry on Health and Social Welfare*, Castonguay Report, Vol. VII, Part 5, Tome 1, "The Professions and Society", p. 15.)

Because the whole purpose of professional law is to safeguard the public interest, we must ask how this function is accomplished. Clearly the public is protected by the assurance of the professional organization that high quality of service will be available. High quality of service, in turn, depends upon a) the *competence* and ethical conduct of

individual professional practitioners, and b) the *availability* of the service through the organization and delivery, or patterns or practice, of professional skills; quality of skill, after all, is of little use to the client if it is not readily available.

In general, it cannot be doubted that professional autonomy self-government has served effectively to promote a) competence. However, as will be argued below, professional self-government has sometimes tended to frustrate b) availability.

Professional control under the law confers upon practitioners not only heavy obligations and responsibilities, but also considerable advantages and privileges, including status, prestige, social mobility, and relatively high rates of remuneration.

Professional control under the law also confers upon the controlling agency, usually the executive council of a college of practice, very considerable power. First, the council will have authority to admit, regulate and discipline its own members. Second, the council, on behalf of the profession, will have both direct and indirect authority over many matters immediately affecting the public; the powers and the policies of the profession bear directly on sensitive areas of social concern and public policy. This point is as

obvious as it is fundamental, particularly when the professional services provided are paid for by the public treasury. The point is acknowledged and underlined by the fact that the powers of the profession and its governing council are derived from public legislation, i.e., from the state. Thus it is apparent that professions have power, both "private" and "public" power, and it is equally apparent and inevitable that the lay public has an important interest in the exercise of professional power and the regulation of the professions.

2. The Case for Professional Self-Government

The case for professional self-government is strong. Professional autonomy is not something which would be or should be tampered with lightly by any authority. Even the most stern critics of professional shortcomings have been circumspect in their approach to the principle of self-government. The Hall Commission (1964) assumed this principle, stating that "'Free and self-governing professions' means the right of members of health professions to practice within the law, to free choice location and type of practice, and to professional self-government". (Vol. I, p. 12.). More recently, the McRuer Report in Ontario sought only to modify but not

destroy professional autonomy, and the Castonguay Report in Quebec, which has resulted in the most sweeping proposals in Canada for regulatory change (Bill 250), sought only "to reconcile the public interest with the incontestable advantages of a certain autonomy of the professions with regard to public authority". (*Op.cit.*, p. 9)

The case for professional self-government, like the jury system in English Common Law, rests upon the principle of judgement by one's peers. Because practitioners must deliver high quality service based upon a shared body of knowledge, they must enjoy a high degree of freedom and independent judgement as to the best application of that knowledge, and it is argued that only a professional peer or equal who partakes of the same body of knowledge can judge adequately the skill or competence of another practitioner. Since quality control is the essence of professional regulation to safeguard the public, and since the layman lacks the knowledge and training to assess quality, standards of performance by a practitioner are seen best to be judged by his own colleagues.

Very delicate matters are involved here. First, since knowledge and scientific truth must be unfettered by arbitrary external restraints, intellectual freedom and independence of informed judgement are highly prized by, and essential to,

professional practice. Second, professional practitioners must exercise not only technical knowledge and skill, but also moral and ethical judgement, if they are to serve their clients best. It follows that any outside interference with their exercise of knowledge and judgement is naturally resisted by professional practitioners. If a practitioner's competence and quality of service is called into question, he demands that it be judged by his professional colleagues who are aware of his problems as well as his knowledge, his code of ethics, and his standards.

It is reasonable to suggest that knowledgeable and highly trained personnel can do their best work and exercise their best judgement only under conditions permitting wide professional latitude and freedom. Just as an artist, craftsman or teacher can perform at a high level of integrity and achievement only if he is relatively unfettered by uninformed interventions and judgements, so too the professional practitioner expects and demands independence and freedom if he is to provide to his clients services of the highest quality. Therefore, professional practitioners place a very high premium upon independence, autonomy and the broadest degree of professional freedom. In these terms, it is clear that professional freedom is no mere shibboleth, but an essential safeguard to the public interest through the maintenance of quality control.

There can be little doubt that the tradition of professional freedom, with its implied condition of self-government, generally has been effective in maintaining quality control. On the whole, professional autonomy has become traditional because it has worked; it has been effective in safeguarding individual clients and the community. Therefore, it is scarcely surprising that a society which highly esteems freedom, including intellectual freedom, should establish and maintain a long tradition of professional independence and self-government.

That long tradition, in turn, has helped to produce an intangible but extremely significant factor which is basic to professionalism: the development of professional pride. Practitioners take great pride in their skills and in the fundamental decency and social utility of their calling. These intangible but important elements cement practitioners' feelings of professional dignity and worth. Without these feelings of pride and dignity, professional people would feel reduced in their own eyes and in the eyes of society. Practitioners might well feel less responsible to their clients and to the observation of professional codes of ethics, and the quality of their service almost certainly would decline. Thus it is difficult to over-estimate the importance of professional pride in the exercise of quality control. Any

public failure to understand this point reflects a failure to understand the essence of "professionalism" and the reason for professional insistence upon self-government: to establish and maintain standards of quality.

3. The Role of the State in the Professional Regulation

In recognition of these facts, the state has usually conferred upon the professions very broad powers of independence and autonomy. The tradition of self-government for professions has been acknowledged by most jurisdictions in the delegation of power by the state to the profession to control and regulate itself.

But it must be emphasized that the state delegates its authority to the profession for the single purpose of protecting the public. So long as professional pride and self-discipline are sufficient to maintain standards and protect the public, the state is satisfied to acknowledge the principle of professional self-government.

Indeed the legislatures of most jurisdictions have implicitly acknowledged that they possess neither the time nor the competence to regulate the professions directly. Legislatures generally have seen fit not only to delegate broad powers of self-government to the professions, but they have also

conferred upon the professions a type and degree of power which is extraordinary: they have granted to the professions monopolistic power.

The professions' power to license practitioners clearly includes the right to exclude "unqualified" practitioners from practice; the power to licence is the power to restrict. Restrictive practice of this kind is by definition monopolistic. As every student of politics knows, power is potentially dangerous, and monopolistic power is potentially extremely dangerous to the public interest. There can be justification for such broad and exclusive professional power only if the public authority can be certain that adequate safeguards exist to protect the public.

Therefore, most jurisdictions not only insist that professional law must be public law, as passed by the legislature and reflecting public policy, but also insist that any by-laws, rules or regulations under professional statutes be reviewed by public authorities and if necessary revoked and repealed by the state. For example, since 1948 the Province of Saskatchewan has written into law the provision that any by-laws, rules or regulations passed by the governing council of a profession must be submitted to the Department of the Provincial Secretary within thirty days of being made, and that these by-laws, rules and regulations may be reviewed by the Legislative Assembly. If these supplementary regulations

under the Act are found by the legislature to be beyond the power of the professional body, or to be prejudicial to the public interest, they may be revoked and repealed. In matters of registration or licensure of a practitioner by a profession, and in matters of discipline of a practitioner by the professional body, the proceedings must be reported to the appropriate Minister of The Crown within fourteen days, and the Minister may, if he thinks the decision unjust, arrange for a Board of Arbitration to settle the dispute between the practitioner and the College of Practice.

Thus it is clear that the principle of state primacy over professional decisions has been understood and established over a considerable period of time. In this manner it has been established that the state has not only a continuing and lively interest in the regulation of professions, but that the state has merely delegated to the professions the power of self-government so long as that power is exercised in a manner consistent with the public interest. The state has not abdicated its ultimate authority, but has established the primacy of public legislation over the private regulatory arrangements of the professions.

It follows that the power of professional self-government has always been in some way qualified and restrained by the ultimate power of the public authority. Self-government

has been a right traditionally enjoyed by the professions, but a qualified right delegated by the state only insofar as that delegation of authority satisfies the criteria of protecting the public interest, and no further.

4. The Case for Increased Public Regulation of Professions

While it is clear that in theory and in law provincial governments have the power to intervene in matters of professional regulation, in practice this power is very rarely exercised. There is little or no evidence in most jurisdictions of careful and continuing scrutiny of professional regulation being exercised by the state. The absence of such supervision or intervention encourages the professions to believe that their self-governing arrangements are a matter of absolute right.

Professions also tend to assume that, because the object of professional regulation is to maintain quality and to protect the public, the interest of the profession must necessarily be identical with the best interest of society. This sweeping assumption is by no means always valid. Indeed it will be argued below that in some respects the interests of a profession and the public interest may be sharply divergent and in conflict.

There is a growing body of literature in the United States which argues that the enormous power of organized medicine is not always exercised in a manner compatible with the public interest. Many writers have observed that organized medicine controls not only the competence of its practitioners, but also the general orientation and goals of the service, and the roles and scope of practice of allied health personnel. It is argued that organized medicine is insufficiently accountable to the public, and that there is evidence of "medical dominance and medical imperialism" over other health care disciplines and over potential changes and reforms in the health care system. For example, one writer, emphasizing the restrictive and monopolistic nature of medical licensure, has stated that "The American Medical Association is perhaps the strongest trade union in the United States". This is the opinion, not of a leftist or socialist writer, but of the right-wing conservative economist Milton Friedman. ("Occupational Licensure", in *Capitalism and Freedom*, Chicago, 1965, p. 150.)

Perhaps the best known American medical sociologist, Professor Eliot Freidson, in his book *Professional Dominance: The Social Structure of Medical Care* (New York, 1970), states flatly that "The medical profession exercises a degree of control over the delivery of health services that precludes

both effective and adequate health care for the majority of the client population". Friedson emphasizes the "dominance" of the medical profession, and argues that "Most of the work under the protective umbrella of medicine...conforms to the special perspective and substantive style of the profession - a perspective that emphasizes the individual rather than the social environment, the treatment of rare and interesting rather than common and uninteresting disorders, the cure rather than the prevention of illness, and preventive medicine rather than what might be called 'preventive welfare' - social services and resources that improve diet, housing, way of life, and motivation of the people without their having to undertake clinical consultation with a practitioner."

Friedson's authoritative views deserve further quotation:

> "Although people in *most* occupations seek to be free to control the level and direction of their work efforts, it is peculiar to professionalism to assert that such freedom is a necessary condition for the proper performance of work. And it is precisely such an emphasis on individual judgement and independence, founded on a concept of the character of the work, that allows the self-regulatory processes of professions to shift from the ideal of responsibility for the action of one's colleagues to concrete responsibility for oneself, to shift from belief in the ideal of responsibility for the public good to the practice of responsibility for the good of one's own personal clientele... The crux of the matter is that expertise is not mere knowledge. It is the practice of knowledge, organized socially

> and serving as the focus for the practitioner's commitment. The worker develops around his work an ideology and, with the best intentions, an 'imperialism' that stresses the technical superiority of his work and his capacity to perform it. This 'imperialist' ideology, built into the individual perspective through training and practice, cannot be overcome by ethical dedication to the public interest. The problem arises, however, when outsiders may no longer evaluate the doctor's work by the rules of logic and the knowledge available to all educated men, and when the only legitimate spokesman on an issue relevant to all men must be someone who is officially certified. This is the central policy issue in the provision of such personal services as health care, an issue underlying such concrete questions as how the services are to be paid for and how they are to be presented to the public. The issue is who is to determine what the goals of the service are and the concrete models by which its goals are to be pursued. Accountability for effective and humane services must, in some way, be more responsive to the lay client himself".

Much the same view is put in more simple language by M. G. Michaelson, M.D., writing on "The Failure of American Medicine" in *The American Scholar*, Fall, 1970:

> "The obsolescence of the American physician today is manifold, a product of his archaic education, his inappropriate orientation to disease and to people, the economic (fee-for-service) and societal (1-to-1) framework of the "physician-patient relationship", the traditional notion of a patient-centered rather than a community-centered responsibility. But the most dangerous aspect of that obsolescence is its established pattern of *physician primacy* in medical care. For centuries the doctor has been considered, and has considered himself, the absolutely central figure in patient care, all-knowing and all-powerful. Despite the fact that advances in medical technology have significantly complicated the physician-patient relationship, doctors have retained their monopoly

> of control over patient care to the exclusion of nurses, technicians, administrators and "para-medical" personnel, without which the practitioner of modern medicine cannot function. Despite brilliant advances in techniques of communication, physicians have jealously preserved their monopoly over health education and information, primarily, it is clear to maintain economic and status advantages. And, most important, despite the easy professional rhetoric of service, our medical care mechanism is run by and for the physician rather than by and for the patient and the practitioner is in no way accountable to the people that he 'serves'."

These extensive quotations from American sources reveal evidence of a growing public and professional concern over medical domination of the health care system, concern over unsatisfactory regulatory arrangements, concern over inefficient patterns of organization and service which do not adequately meet the needs of society. These authors are not contesting the fundamental decency, integrity, skill, and dedication of the individual practitioner. On the contrary, all call into question only the power of organized medicine and the nature of the system.

In the Canadian context, these same fundamental points have been made many times. Most recently the Hastings Report has stated that one of the main reasons for establishing the Community Health Centre Project was a feeling that "better health care is not coming out of an (increasingly) expensive medical care system, and that medical care delivery

could be better organized. *It is the system rather than the individuals in it which is at fault*". (p.14).

Perhaps the most synoptic and reasonable statement of the complex relationships between the state and health professions is to be found at the beginning Chapter 25 on "Regulation" of the *Report of the Committee on Healing Arts*, Vol. 3, p. 29. The Committee pronounced in favour of:

> ..."a policy of maximum self-government, consistent with the public interest. But in stating that policy, we must never lose sight of the fact that the right to such self-government is a delegation from the state by its popularly elected legislature and imposes on the profession or group a corresponding trust to see that the right is exercised in the public interest. It cannot be overemphasized that primacy of the public interest must be the cornerstone of any regulatory structure. Where there is conflict between the interests of the public and the interests of the profession or group, the professional or group interests must yield to those of the public; but, to the extent that it is possible to do so by statute or regulation, conflict should be avoided. Similarly, unnecessary interference with self-government should be avoided. It would be folly to ignore or minimize the importance of pride in a profession. Indeed, it is in the highest public interest that there should be professional pride in the provision of such essential services. At the same time, society can no longer afford to tolerate a total abdication by government of the right to guide,direct and, in some areas, become directly involved in the affairs of the professions. The absence of any such guidance, direction and involvement can be blamed for the fact that there has been an absence of planning in a meaningful way for the new and increased role which members of the various professions and occupational groups are expected to play in modern society. The present problems of manpower and lack of complete harmony with relation to sister professions in an era of increasing

> teamwork in health care are but two illustrations of the effect of the abdication referred to. Another is the professionally oriented interpretation that the professions have given to the concept of unprofessional conduct to the possible prejudice of the public interest, as shown throughout this Report."

That is the best single statement of the issue in Canada, and it is a statement with which the present writer entirely concurs.

It is only reasonable to recognize that professions, like other groups and individuals in society, may well be expected to have certain private self-interests of their own which are not coincident with the public interest. Recognition of a degree of real or at least potential conflict between the private interest of a profession and the public interest is the root of the necessary distinction between the professional or licensing body on the one hand, whose purpose is to enforce standards of quality and service, and the voluntary association of the profession on the other hand, whose legitimate function is to advance the particular interests of the profession and its membership. This important distinction between the public function of the licensing body and the private function of the voluntary association is now widely recognized in Canada. From the standpoint of both the professions and the public, it is desirable that the separation of the two functions be kept sharp and distinct.

Clearly there can be conflict between the voluntary association and the public interest, and such conflict can be resolved through negotiation, but in what way might conflict also arise between the professional college and the public? Conflict may arise in several areas.

First, in the matter of remuneration and fees the actions of the professional college may have a direct or indirect influence on fee schedules, or, in the absence of a voluntary association,the professional body may itself set the fees of its practitioners at an excessively high rate. An argument can be made that any and all professional fees should be reviewed by a public body. Where professional fees are paid out of the public treasury, it is of course essential to prevent the unilateral setting of fees by the profession and to substitute negotiation procedures between the profession and the state to establish reasonable rates of remuneration in the public interest. If arrangements have already been established for the negotiation of fees, as they have in Saskatchewan between physicians and the state, no major problem need arise in this area, but it is important that the principle of fee negotiation rather than unilateral setting of fees be maintained if and when public health insurance payments are extended to the services of other professions.

Second, it is possible that conflict could arise over matters of the discipline of practitioners. Here there is

little or no evidence that professional bodies deal more lightly with breaches of discipline by their members than would public tribunals. Still, the public may continue to entertain with some justification the fear that it is extremely difficult to obtain in a court of law the testimony of professional practitioners against another practitioner charged with negligence or malpractice. Where disciplinary matters are involved it is important not only that justice be done but also that it appear to be done. Since it is presumed that in disciplinary matters professional bodies have nothing to hide, it seems desirable that representatives of the lay public sit on the disciplinary committees of the colleges as well as the complaints committees, and that the public should be able to be informed by lay representatives of the workings of disciplinary procedures.

Third, the inherently monopolistic nature of licensing can lead to strain between the profession and the public with regard to restrictive practice and limited entry to the profession. In some jurisdictions, doubts have arisen as to whether the licensing authority has been altogether fair in its consideration of the qualifications of foreign trained practitioners. This does not appear to have been a serious problem in Saskatchewan. However, difficulties may arise with regard to domestic health personnel. Educational arrange-

ments as well as licensing requirements may make it difficult or impossible for practitioners of certain health disciplines to rise in the hierarchy of skills and obtain professional licensure. For example, barriers may exist which prevent a dental hygienist or dental assistant from being admitted to the educational programme leading to licensure as a dentist, or a nursing assistant with only grade 11 education who may find it impossible to upgrade her skills to become a registered nurse or a degree nurse; similarly, it seems likely that a nurse practitioner or physician's associate with proven skills and experience might in the future find it extremely difficult to secure entry to an educational programme leading to the degree of M.D. Wherever possible, in terms of elementary justice, civil liberties, and manpower supply, it is extremely desirable that excessive barriers not be placed in the career development of health practitioners and other professional or semi-professional personnel, and that unnecessary barriers to professional advancement should be reduced or removed.

Fourth, a serious area of conflict between professional interest and the public interest appears to exist in the matter of relations between various disciplines and professions in the matter of legislative definitions of scope of practice. This is an area in which the law is at fault, but for various reasons scope of practice legislation is often unduly narrow

and restrictive, preventing the addition or substitution of various mixes of skills for the services of the profesional practitioner. The Hastings Report, like other earlier reports and studies, has emphasized the importance of the development of an inter-disciplinary team of health practitioners in which roles and scope of practice are not narrowly delimited. Legislation which unduly restricts the scope of practice of various personnel can inhibit the development of the health team and be prejudicial to the public interest. The Hastings Report (p. 13) states that:

(1) "In organized and supervised settings, a team of various types of personnel, each member of which carries out specific functions, definitely increases the efficiency and productivity of the physician, dentist, and other professional personnel as compared to situations of solo and largely unsupported forms of practice."

(2) "It is also definitely possible to substitute less highly trained professional and technological personnel for more skilled personnel in organized and supervised settings, such as hospitals, health centres, and group practices, without any danger to public safety or diminution in quality of health care. This is also true in situations where only limited supervision is possible, such as the north, provided back-up and referral services are reasonably available."

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater

supply and accessibility of service through the development of team practice. Therefore, it is urged that: professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority. Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

Fifth, in the "technological society" in which there is heavy pressure toward the attainment of fully professional status, there is always a danger that a proliferation of new "professions" may lead to the creation of new restrictive practices and new barriers to inter-disciplinary cooperation. In this regard, it is urged that no one profession should have control over the scope of practice of another profession or discipline and, more important, that the principle of licensure should not be extended to newly emergent disciplines, but that certification or registration procedures should take the place of licensure unless the service

provided is such as to present a clear and direct danger to the public safety.

Sixth, conflict between the private professional interest and the public interest may arise merely because professional law itself may become dated or obsolete. The professional law, unless periodically reviewed, may no longer reflect rapidly changing social needs and social realities. Again it is clear that such inadequacies of the public law can scarcely be blamed on the professions; it is the duty of the state to alter its own legislation so that the conditions and arrangements of professional regulation accurately reflect current public policy. There is always a danger that gaps may develop between the regulatory arrangements of the professions and the contemporary needs and desires of society.

For these reasons, it is always possible that misunderstanding, strain or conflict may arise between the state and the professions. The long tradition of professional self-government naturally implies that the state will approach changes in professional law only hesitantly and with circumspection, always mindful that alteration of professional law is a delicate matter and that highly sensitive issues of professional pride and competence are involved.

Because the complex interrelationships of the state and the professions have been more extensively studied

in the provinces of Ontario and Quebec than elsewhere in Canada in recent years, the following sections will be devoted to an examination of the experience and proposals for change in these two provinces.

5. Precedents in Ontario

In Ontario the McRuer Report, the *Royal Commission Inquiry into Civil Rights*, has had a very great impact on public policy. The McRuer Report has been acclaimed as a major document, and already most of its recommendations have been translated into law. One section of the McRuer Report (Vol. 3, section 4) is devoted to the professions, and McRuer's language is vigorous and straight-forward.

He states that, "The granting of self-government is a delegation of legislative and judicial functions and can only be justified as a safeguard to the public interest. The power is not conferred to give or reinforce a professional or occupational status. The relevant question is not, 'do the practitioners of this occupation desire the power for self-government?', but 'is self-government necessary for the protection of the public?' No right of self-government should be claimed merely because the term 'profession' has been attached to the occupation. The power of self-government

should not be extended beyond the present limitations, unless it is clearly established that the public interest demands it." (Vol. 3, p. 1162.)

McRuer acknowledges the importance of professional self-government in the matter of quality control, but he adds that: "excessively high standards may produce specialists but leave a vacuum with respect to areas of a profession where the services of a specialist are not required."

McRuer goes on to state (Vol. 3., p. 1163) that: "The traditional justification for giving powers of self-regulation to any body is that the members of the body are best qualified to ensure that proper standards of competence and ethics are set and maintained. There is a clear public interest in the creation and observance of such standards. This public interest may have been well served by the respective bodies which have brought to their task an awareness of their responsibility to the public they serve, but there is a real risk that the power may be exercised in the interests of the profession or occupation rather than in that of the public. This risk requires adequate safeguards to ensure that injury to the public interest does not arise. We recommend that the principle applied in creating the British Medical Council be adopted in Ontario. Lay members should be appointed by the Lieutenant Governor in Council to the governing bodies of all self-governing professions and occupations".

In 1970 the principles of the McRuer Report were underlined and elaborated by the *Report of the Committee on the Healing Arts* (see Vol. 3, Chapter 25) which made numerous and detailed recommendations for the education and regulation of the health disciplines. This Committee sought to retain the principle of licensure for the senior health professions, but urged the application of certification or registration for any and all newly emergent disciplines not already granted the powers of licensure. At the same time, the Committee sought to expand the scope of practice of various health disciplines and to facilitate the emergence of the health team. The Committee rejected the concept of a narrow and exclusive definition of the practice of medicine, urged the development of inter-disciplinary team practice, and recommended that violations of the Medical Act involving the scope of practice of allied health personnel should be prosecuted only with the prior consent to the appropriate public authorities, that is, the Minister of Health.

After examining a large number of apparently restrictive practices indulged in by various healing professions, the Committee observed that: "inability to be objective in discerning the public interest as opposed to professional interest, and the assumption that the two interests coincide because the profession is public spirited, are common to all professions." For this reason, the Committee urged that

all professional regulations be reviewed constantly by the Minister of Health with the assistance of his legal advisors.

The Committee noted the dominant power of organized medicine in the health system, and noted also that it had heard many expressions of apprehension from other health professions and disciplines other than medicine, that physicians often appear to exert an undue influence over health administration and policy. "While we think it likely that the medical profession will always deserve and be accorded great respect in the assertion of its views on health policy, there may indeed be much to gain by dispelling the appearance of disproportionate influence of the medical profession by reason of the constitution of the senior levels of the Department of Health." That is, there is no inherent reason why the Minister, the Deputy, or the senior staff of the Department of Health must necessarily be physicians.

Evidence of frequent inter-professional conflict and of increasing demands by many groups for "professional" status lead the Committee to recommend that "in the interest of the coordinated health programme, the continuous growth of independent governing bodies should be stopped." Disciplines not presently licensed should not be granted licensure, but should instead have their membership certified or registered, and the principle of self-government ought not to be extended.

It was further recommended that members of the lay public be appointed by the government to the governing bodies of the professions "in sufficient numbers to ensure effective rather than nominal representation of the public. Lay appointees should not, however, constitute the majority of members on such bodies." Licensing bodies of the professions should have no control over the admission requirements or curricula of publicly supported professional schools. The Committee also insisted upon a more clear and formal separation between the functions of the licensing body (as the trustee for the public) and the voluntary professional organization (as the spokesman for the profession). Emphasis was also placed upon the need for programmes of continuing education, at least for the senior health professions, and the responsibility for such programmes was assigned not to the licensing body but to the respective professioal educational institutions.

In order to overcome the apparent "balkanization" of the health disciplines, the Committee on the Healing Arts recommended the creation of a Health Disciplines Regulation Board, possessing a degree of independence from interference in its affairs by government, but nevertheless the chosen agency through which the government's health disciplines policies would be administered. The Board should be small, perhaps five in number, appointed by the Crown, and comprised of a "bare

majority" of lay members. The senior health professions of medicine, dentistry, and nursing would continue to enjoy self-government, but all other disciplines would have their regulatory arrangements under the control of the Board. The Board would be responsible for the decision-making involved in the licensing, certifying, or registering, and the disciplining of practitioners under its jurisdiction. There would be a Division for each individual discipline under the Board, and each Division would contain lay appointed members plus a "bare majority" of practitioners from the discipline regulated by that Division. Main functions of the Board were seen to be the reduction of inter-professional or inter-disciplinary conflict, and conflict between disciplines and the public, and to ensure that regulatory arrangements were consistent with public policy. Provision was also made for appeals, by any person affected by the decision of a Division, to the Board, and ultimately to the Courts. Regulatory problems involving members of the senior professions were to be dealt with by the Health Commissioner (or Health Ombudsman) whose duties would include investigation of complaints from practitioners or patients and reporting to the government and the public the results of his investigations.

The recommendations put forward by the Committee on the Healing Arts were reviewed for more than a year by sub-

committees of the Ontario Government's permanent health advisory body, the Ontario Council of Health. The Ontario Council of Health decided to go further than the proposals of the Committee on the Healing Arts and recommended that all health professions and disciplines, including medicine, dentistry, and nursing, should come under the review and jurisdiction of the Health Disciplines Regulation Board.

Accordingly, the Department of Health prepared tentative draft legislation which was submitted to the legislature in June, 1972, proposing the establishment of a general umbrella regulatory body to be known as the Health Disciplines Regulation Board. The draft for a Health Disciplines Act contains two parts: Part One of the proposed legislation deals with the establishment of the Board and emanates from the government; Part Two, dealing with the establishment of Divisions or Colleges under the Board, represents the proposals made by existing licensing bodies and contains the suggestions of these bodies for new Acts for the regulation of their individual disciplines. Many proposals in Part Two are not necessarily acceptable to the government and may require considerable revision before the Act is re-submitted to the legislature. (As of July, 1973, certain provisions of Part Two are still under discussion, and the Act has not yet been passed.)

The existing draft proposes that seven citizens, laymen who are not members of any of the health disciplines, will be named to the Health Disciplines Board, and public representation is also proposed on the governing bodies of each of the Colleges, as well as for their complaints and discipline committees.

The Health Disciplines Board will review and supervise the activities of the College councils, from which it will require reports and information from college registrars. It will review legislation respecting the provision of services by designated disciplines, conduct hearings, and perform any other such duties as may be assigned to it by the government. The Board may make regulations which, in areas of conflict, will over-ride regulations of the individual Colleges. The Board will also submit an annual report to the Minister. The Board will be further empowered to hear appeals from applicants refused registration by a college as well as appeals from members of the public dissatisfied with the way a college has handled their complaints. Thus Part One of the draft legislation gives to the Board power to over-ride the regulatory decisions and arrangements of an individual College.

However, conflict has already arisen insofar as Part Two does not in its present form reflect any consequent duty or

obligation on the part of the Colleges to obey the rulings and commands of the Board. Unless the provisions of Part Two are altered, and unless the individual professional Acts are in fact altered, the Health Disciplines Act may perpetuate existing "separatism" of the professions under the guise of integration and cooperation. Extensive revision of both Parts of the Act is likely, but unless the Board is given some teeth and the power to impose real sanctions on the individual colleges, it is possible that the draft Act may be mere window-dressing and will fail to create real change or real inter-disciplinary cooperation. Many of the particular professions and disciplines appear to be attempting to maintain the status quo in defiance of the government's apparent intention to bring about greater inter-disciplinary cooperation and the development of a health team. As yet the draft contains no provision for the regulation of the new category "nurse practitioner" or "physician's associate", nor does it contain provision for regulation of personnel in the mental health field.

Therefore, the Ontario draft Health Disciplines Act is not a suitable model, in its present form, for the guidance or imitation of other jurisdictions. Most of the proposals under Part Two of the Act appear to perpetuate the assumption of solo practice rather than team practice, and to maintain

the relative isolation of individual disciplines. For example, the Act still gives to the College of Physicians and Surgeons the right to prosecute allied health personnel for practising medicine in violation of the Medical Act, and does not require the consent of either the Minister or the Board before such prosecutions can be undertaken. That is, the role and scope of practice of allied health personnel may continue to be sharply limited. Then too, the section on Pharmacy continues the existing but obsolete provision that only a licensed pharmacist can employ other pharmacists or own and operate a pharmacy by a community health clinic or other form of team practice. Other such examples could be cited from the Act which reflect a general failure on the part of many professions to appreciate the necessity for change and the primacy of the Health Disciplines Board as an instrument of public policy. While there is much merit to Part One of the Act, Part Two seems to require extensive rethinking and fundamental revision.

6. Precedents in Quebec

The most general frontal assault on professional autonomy in Canada has been launched in the province of Quebec. *The Report of the Commission of Inquiry on Health and Social Welfare* (the Castonguay Report, 1970) devoted a separate volume (VII)

to an examination of "The Professions and Society". The main thrust of this Report was to argue that professional law ought to come under more constant supervision by the state, that professional licensing bodies performed a public role essential to the functioning of the state, including (through regulatory procedures) legislative and judicial functions, and that "the needs of the professions and of society are not necessarily identical" (p. 17).

The Castonguay Report recommended that a general Code of Ethics be established and adopted for all professions to replace the present "mosaic" of laws governing occupations, that no profession should be made subordinate to the control of another profession, that the rigid delimitation of areas of practice for various professions be made more flexible when a profession is practised within an organized setting of group or collective practice, that the governing council of a profession be composed of an absolute majority of members elected by and from the profession but with a significant component of lay membership added, that there should be established for each profession a "professional inspection committee" composed of members of the profession plus representatives of the public, that the disciplinary tribunal or committee of each profession be composed of practitioners, presided over by an attorney selected by the Chief Justice

of the Supreme Court of the province, that the final power of control over all professional bodies be vested in a separate Department of the provincial government, and that the provincial government be entrusted with final authority over all disciplinary and regulatory arrangements of the profession.

In the Autumn of 1971 the recommendations of the Castonguay Report with regard to professional regulation were elaborated and formulated as Bill 250, a draft statute which has undergone considerable revision and was not re-submitted to the legislature until 1973. Bill 250 has proven to be highly controversial and has excited much critical comment. This legislation is extremely complex and detailed. It provides that the disciplinary committee of each profession be headed by a government-appointed lawyer to decide who should be penalized or expelled for infractions of the profession's code of ethics. It provides for lay membership on the governing council of each profession, and the creation of a Quebec Interprofessional Council including one member from each of thirty-four professions. These professions include not only the health disciplines, but also lawyers, engineers, accountants, and many other occupations. The Interprofessional Council, in turn, will be subordinate to a Quebec Professions Board made up of three lay members appointed by the government after consultation with the Interprofessional Council. The Professions

Board has the power to draw up a general code of ethics for all professions, investigate and inspect the accounts of all professions, generally supervise all regulatory matters, and hear appeals by practitioners against any individual profession or discipline which might deny membership to the appellant. All professional fees and fee schedules must be approved by the Board as the agent for the government.

Bill 250 brings the professions in Quebec under more direct and stringent government control than is yet contemplated by any other Canadian province. It is clear that this legislation gives the government sweeping powers over professional regulation. The Bill appears to go very far toward qualification or abridgement of the power of self-government by professions and, not surprisingly, the Bill has come under heavy attack from many professions.

It is extremely difficult for people outside of Quebec to arrive at objective judgements concerning Bill 250. Quebec is not a "common law" jurisdiction like the other provinces of Canada, and circumstances and conditions in Quebec may be unlike those found in other provinces. Not only are the problems and circumstances of professions in Quebec unique, but attitudes and opinions may also be different.

There are many reasons for reserving judgement on the

effects and implications of Bill 250. First, it is clear that this draft statute of 1971 was re-submitted to the provincial legislature in 1973 only after substantial modification. There has been evidence of strong resistance to the Bill on the part of many professions. Second, even those who believe that the theory and principles of the Bill may be sound recognize that it may be difficult to put into practice. Third, while there is little evidence that the health professions and even the senior health disciplines particularly resent or resist some degree of government supervision and control, since their remuneration derives mainly from the public treasury, there is evidence that other professions (including law) have resisted the spread of government control to areas not hitherto encroached upon directly by public policy. Fourth, it is evident that professional personnel in the province of Quebec may be less mobile than professions in other Canadian provinces and may therefore acquiesce to further extentions of state control over the professions more readily than would be the case in other provinces.

Because Bill 250 has undergone such prolonged discussion and negotiation since 1971, because the Bill has not yet been passed by the provincial legislature, and because Quebec's circumstances are somewhat unique in Canada, it would seem pre-

mature for other provincial jurisdictions to imitate this legislation at the present time. Even if it were acknowledged that Quebec's Bill 250 is sound and reasonable in principle, until the Bill has been tested in practice, it seems desirable that other provincial jurisdictions in Canada should reserve judgement as to implications and results of this draft legislation, and that other provinces should think twice before imitating it.

The present writer believes that the theory and principles underlying this Quebec legislation are fundamentally sound and reasonable. However, it would be folly to suggest that untried and untested legislation should quickly be imitated in other provinces. If it proves that many professions are antagonized or alienated by this legislation, or that it becomes necessary to modify the legislation substantially, other provinces which rushed forward with similar legislative proposals might find themselves in an embarrassing position. Until it is discovered in practice whether Bill 250 will work, it deserves our careful attention, but need not be copied in other jurisdictions at the present time.

But the significance of Quebec's Bill 250 cannot be over-estimated. It is clear that this legislation represents a bold first attempt to bring the power of the professions under more direct public control. It is also apparent that this

legislative proposal signifies to all of the professions in Canada the considered future intention of many governments to bring professional law and regulation more directly into line with social need and public policy. It would not be premature for other provincial administrations to begin serious discussion with the professions concerning the implications of this Bill and the probable legislative responses which will be necessary to bring about a clearer and more direct accommodation between professional interests and the public interest. There can be no doubt that extensive revision and amendment of existing arrangements for professional regulation will have to be undertaken across Canada. This point is underlined by the recommendations of the Hastings Report insofar as they touch upon matters of professional regulation and the development of team practice in the health disciplines.

Although the province of Quebec can lay claim to being somewhat in advance of other provinces in its development of legislation pertaining to the regulation of professions, there are serious criticisms which may be levelled at the legislation now being evolved in Quebec pertaining to the health disciplines, and particularly with regard to Bill 252, the Medical Act, as it is presently proposed. The criticism may be levelled most particularly at Section VI of the draft Medical Act concerning the "Practice of Medicine". Section VI of the Medical

Act of Quebec provides that "every Act having as its object to diagnose or treat any deficiency in the health of a human being constitutes the practice of medicine. The practice of medicine shall comprise, in particular, medical consultation, the prescribing of medication or treatment, attendance at confinements, establishing and controlling diagnoses and treatment of illness or diseases." The Act also states that "subject to the rights and privileges expressly granted by law to other professionals the Acts described...shall be reserved to physicians."

To this writer, and to many legal commentators in the field, it seems unnecessary and undesirable that the Medical Act of any province should include such a narrow and restrictive definition of the practice of medicine. Such definitions and restrictions may seriously inhibit the development of group or team practice of the delivery of health care. If the skills of allied health personnel are to be applied effectively to health care, and if team practice is to develop, it seems undesirable that such precise and rigid definitions of the practice of medicine should be written into law. To define is to limit and to set down arbitrary boundaries, and in an era characterized by the rapid pace of technological development in new techniques and new educational processes, it is now inappropriate to delimit the practice of medicine to any

one group or profession. There can be no doubt that the growing skills of various types of allied health personnel can be used effectively to supplement and complement the skills of physicians in the delivery of health care. (Compare *Report of the Committee on Healing Arts*, Vol. III, p. 37-38.) There may be an anomoly in Quebec's Bill 252 in the excessively narrow definition of the practice of medicine. Since technological change is so rapid, it appears likely that any precise definition of the practice of medicine will quickly become obsolete and may unduly restrict the role, scope of practice, and application of skills of other professional disciplines and allied health personnel. The Medical Act of any province should not be so narrow as to deprive the public of the services of allied health personnel, and should not cause physicians to undertake routine procedures for which they are over-trained or over-qualified; the Medical Act should not preclude the substitution of paramedical skills for medical skills or prevent allied health personnel from performing services which in the past have been considered as part of the practice of medicine. Legislative definitions must be sufficiently broad and flexible to permit, within the bounds of public safety, other health personnel to expand their scope of practice within the bounds of their competence and to facilitate the development of the health team in the multi-

discipline clinical setting. In short, there appears to be no reason for the inclusion in Quebec's Bill 252 of a narrow and restrictive definition of the practice of medicine in such limited terms. Again, this point is underlined in the recommendations of the Hastings Report.

7. The Hastings Report Recommendations on Regulation

During the next few years in Canada the debate over reform over the health care system is almost certain to focus upon the recommendations of the Hastings Report. It is an excellent and important document. Whereas the Saskatchewan experience after 1962, and the Hall Commission Report in 1964, laid the basis for public health insurance programmes all across Canada, the Hastings Report provides the central blueprint for reorganization of services and improvement in the quality and accessibility of the services insured. Already this Report has been endorsed "in principle" by Canada's Ministers of Health in their meeting of May, 1973.

The Hastings Report recommends the creation of community health centres or community health and social service centres in all parts of the country. Because the provision of ambulatory clinical care through community health centres requires the operation of a genuine, inter-disciplinary health team, the Hastings Report lays heavy stress

upon the development of the health team. As the Report states, "The central concept of the community health centre is teamwork. The kind of teamwork which is meant is not the kind of teamwork which has been developed in hospital operating theatres, a para-military system to deal with the inert patients, but the milieu therapy approach, developed first in mental hospitals, and later in community psychiatry. This approach recognizes that all those who have contact with the client may influence his behaviour and his self-concepts, but that professionals have a special responsibility in making their interventions not only to help the patient but to help others to help him, and to help him to help himself." (p. 9).

It is clear that the emergence of the health team will have to be assisted and encouraged not only through change in professional statutes but also through changes in attitudes and changes in the work setting. The Report states that members of the Hastings Committee were forcibly struck by frequent and strong expressions of opinion by many professional and technological groups that their skills are not presently being used to full effect in patient care. They point out that no one person or type of practitioner can have complete understanding and competence in all areas of health service.

Many groups and professions, particularly the nurses, "made clear their unwillingness to continue accepting the dominance of the physician in providing health care. They see themselves as possessing a depth of knowledge and skill in their particular area that surpasses the knowledge and skill of the physician. Most do not question the general leadership role of the physician in the *medical* supervision of families and individuals and, in particular, his special position in decisions affecting illness and death, but they do state unequivocally that they are no longer willing to accept an auxiliary or purely subsidiary role in the *health* care process. They feel that the insights and skills they possess can only be effectively used to help people when a collegial or team relationship exists on all health personnel." (p. 16)

The Hastings Committee acknowledges that some of these feelings of frustration on the part of allied health personnel may arise from the "normal ambition" of various groups to achieve greater status and income. However, the Report concludes that these feelings of frustration on the part of many groups "are the result of what are seen as unnecessary restrictions placed on the role these professionals could play by the medical (and dental) profession. Such restrictions are often presented as necessary steps for protecting

the public and ensuring quality of care. While such motives are worthy, they are not always easy to distinguish from self-interest." (p. 16).

The Hastings Report also acknowledges the positive effects of regulatory arrangements for the professions so long as it is understood that the sole purpose of professional reulation is to protect the public and not to advance the interests of the profession. The Report goes on to suggest that: "To ensure effective community and individual involvement in the mechanisms of the health system, there must be an effective 'lay', that is, non-professional, participation and representation on the regulatory bodies of the health professions. Professional statutes should be amended, where necessary, to ensure that no profession can, directly or indirectly, regulate the members of another profession or occupation. Amendments of this kind would also have the effect of eliminating the inhibiting effect which some licensing statutes, for example, provincial Medical Acts, have on the rational allocation of functions or roles among members of different health professions" (p. 33). It is also urged that the legal mechanisms and standards relating to roles, responsibilities, functions and institutions should be as uniform as possible from one jurisdiction to another in Canada in order to facilitate effective

manpower policies and to facilitate mobility of both professionals and patients.

The Hastings Committee emphasizes that "precise and rigid fixing of roles, responsibilities and functions of professionals and institutions through statute or licensing regulations would constitute a serious obstacle to the development of effective programmes, true teamwork, and innovation. There are, for instance, real disadvantages and practical problems in trying to distinguish a single 'medical act' from a 'nursing act' in a situation where changing and flexible roles are necessary" (p. 20). It is evident that in most provinces existing professional licensing legislation will require review and modification insofar as statutes currently in force may prevent some prospective members of the health team from becoming full colleagues of other practitioners who are not members of the same profession. In particular the Report points to the field of pharmacy where, in most provinces as in Saskatchewan, unless the Pharmacy Act is amended, it may be impossible for the community health centre to have a pharmacy as an integral part of the services provided.

8. Review of Existing Saskatchewan Health Professions Acts

In an environment of rapid change in which almost all existing social institutions and legislation require frequent review and revision, it should be obvious that any review of existing statutes is by no means intended to denigrate either the competence or the goodwill of legislators or legislative draftsmen. Indeed it is apparent that Saskatchewan has been well served by legal advisors and legislative draftsmen reflecting high degrees of care and skill.

But the problem is that the rate of change in technology and social policy may have overtaken, and in some instances rendered unsatisfactory or obsolete, some provisions of existing professional acts. These acts were not drafted in an era of collective team practice through institutions such as community health centres; these acts were not drafted to reflect the new and complex requirements of public policy, policy such as that contained in the recommendations of the Hastings Report. In order to accommodate the requirements of team practice in a community health centre setting, it is natural and inevitable that legislative amendment may be necessary.

To perform a thorough and detailed review of all existing health professions legislation in Saskatchewan

would require legal skills and experience not possessed by the present writer. Accordingly, consultation was sought from one of Canada's acknowledged experts in this field, Professor Horace Krever, Faculty of Law, University of Western Ontario; Professor Krever was the principal draftsman of the sections on Regulation in both the Report of the Ontario Committee on the Healing Arts and the Hastings Report. Unfortunately Professor Krever had only very limited time available to review existing health professions legislation in Saskatchewan, and was able to provide only a few general but perceptive observations concerning fundamental principles. Thus the comments below are not intended to be detailed or exhaustive.

The observations and proposals that follow are not in any major way at variance with the conclusions reached by a review of existing Saskatchewan legislation carried out earlier by members of the Research and Planning Branch of the Department of Public Health with the assistance of the Department's legal advisor.

First, the existing legislation appears to perpetuate a proliferation of "independent" professions and makes insufficient provision for inter-professional cooperation and integration of service. The premise of most existing statutes appears to be an implicit assumption of the contin-

uation of solo practice rather than integrated team practice as contemplated in this paper and in the Hastings Report.

Second, it is noteworthy and salutary that since 1948 professional statutes in this province have included provision for review of rules, by-laws and regulations under the Acts by the Lieutenant Governor in Council; the ultimate authority of the public through the Crown has been established. However, there is little evidence that this public power has in fact been much exercised. More important, this residual power of the Crown to review or to repeal regulations under a professional Act is of little consequence if the professional statute itself does not contain adequate expressions of contemporary public policy consistent with existing social needs. It may well be that the publication, widespread discussion, and eventual adoption of the principal recommendations of the Hastings Report may render obsolete the major professional Acts of most provinces, and require their extensive review and detailed revision.

Third, existing professional legislation in this province reflects an excessive concern with somewhat legalistic and limiting definitions of role and scope of practice for many disciplines and professions. As argued above, there appears to be little or no reason for a precise and restrictive definition of the practice of medicine as contained in

the Medical Act. The fundamental question here is: why define? One answer may be to protect the interests of the individual profession and restrict practice to members of that profession only, but such reasoning tends to be in the professional interest and contrary to the public interest. Fixed legal delimitations on scope of practice would set a limitation on the role of a practitioner in a manner inconsistent with the obviously rapid rate of technological change which constantly expands the boundaries of modern professional practice. Again, definitions of scope of practice might direct the education of practitioners more precisely, but such definitions are not required because the professional educational authorities are usually careful and competent and require no such statutory definition for the educational process. Under a licensing scheme, definitions of scope of practice might serve to warn others not licensed precisely what they may and may not do without threat of prosecution; however, in practice such narrow definitions are violated everyday by practitioners of other professions and disciplines and thus serve no real or effective purpose. Definitions, in fact, tend greatly to inhibit the application and effective utilization of the skills of related disciplines and allied personnel. The development of inter-professional cooperation, rational allocation of functions, and the emergence of

collective or team practice is artificially inhibited. Therefore,since there appears to be no real danger to the public interest in the absence of precise definitions of scope of practice, and since violations of the scope of professional practice can reasonably be left to public authorities and to the courts to interpret, there appears in fact to be no reason for the continuation of rigid and narrow definitions of scope of practice in professional health legislation.

Fourth, existing professional Acts perpetuate the control of one discipline by another discipline in a manner prejudicial to the group interest of the subordinate body and prejudicial to the public interest. It is difficult to discover any reasonable principle by which, for example, nursing assistants must necessarily be under the control of registered nurses, or why dental auxiliaries must be controlled by dentists. There is always real potential danger in the control of one discipline by another, and such control should be abolished.

Fifth, existing Saskatchewan professional legislation appears to prevent several professions, including optometrists, pharmacists, chiropractors, and chiropodists, from working in a team or group setting such as a community health centre. The Acts governing these several professions prohibit the

employment of such professional practitioners by any person or institution other than members of the same discipline. This provision of existing legislation appears not only to inhibit but absolutely to prevent the functioning, for example, of an optometrist or a pharmacist as a member of an integrated team within a community health clinic setting. These provisions of existing law should be abolished.

Sixth, in order to encourage and facilitate the development of community health centres as contemplated in this paper and in the Hastings Report, new legislation will be required to give legal status and recognition to the concepts of team practice and collective responsibility for health care. In this regard it would be difficult to improve upon the terse language of the Hastings Report:

> Although present legislation does not specifically prohibit the emergence of community health centres, it is the Committee's view that appropriate legislation could help to create a climate in which their growth might be encouraged. For example, community health centres should be recognized as legal entities with the status to contract and to sue and be sued.
>
> The concept of community health centres we have proposed requires "corporate" or collective responsibility for the professional actions of all its personnel whatever their individual status in law may be (i.e. irrespective of their position as "independent contractor" or employee). Traditionally,

> the practitioner has been individually responsible to the patient. That responsibility has been extended to or shared by another person or corporation only where the relationship between the practitioner and that other person or corporation was that of employer and employee. While individuals should continue to be held responsible for their performance, this traditional basis of vicarious liability may not be an equitable or meaningful notion or, indeed, an appropriate mechanism for protecting the patient, in an era of patient care by an integrated team of health professionals in an institutional setting. Such corporate responsibility would complement the team approach since it would foster flexibility and diversity in the provision of care. In addition, direct corporate responsibility would clarify some problems relating to volunteer workers and student health practitioners. At present, it is unclear where responsibility lies for those persons since they are likely not employees of the institution in which the care is provided.
>
> Corporate responsibility would give persons cared for through a health centre redress against the centre for professional negligence on the part of team members, encourage physicians and other professionals to delegate tasks which can safely be carried out by other health workers by removing the basis for their continually expressed belief that responsiblity for quality ot care resides in them alone. And, finally would enable professionals and other health workers to enter into contracts of service with the centre and thus give them a sense of security.

Therefore, it seems desirable that each province should enact new legislation providing for the legal recognition and establishment of separate entities called community health centres which would accept corporate or collective responsibility for patient care. At the very least, specific legislative exemption should be provided for various professions

and disciplines operating together as a health team from any threat of prosecution for violating scope of practice legislation or the scope of the practice of medicine as defined in the Medical Act.

9. Recommendations

IT IS RECOMMENDED:

(1) That the safety of the public and the protection of the public interest be understood and accepted as the sole purpose and goal of professional health legislation.

(2) That the Government of Saskatchewan review and where necessary revise all existing statutes dealing with the health professions to ensure that the various professional Acts adequately reflect existing social needs and public policy to facilitate the development of an integrated and more universally accessible health care system.

(3) That the Government of Saskatchewan take steps to end the proliferation of "independent" and self-governing professions, and that certification or registration procedures be substituted for licensure unless a clear danger exists threatening the public safety.

(4) That a significant component of knowledgeable lay members be added to the executive councils of professional regulatory colleges, including the Complaints and Disciplinary committees of the colleges.

(5) That members of the individual professions continue to constitute a majority of the executive council of colleges of practice and licensing bodies, and that matters of quality control and competence continue to be under the control of the individual college or licensing body, with the further provision that individual practitioners of a profession subject to disciplinary procedures enjoy a right of appeal to a higher public authority and the courts.

(6) That there be established a Health Disciplines Regulation Board with the power to review and if necessary to revoke regulations made by the individual professional colleges; that the Board consist of not fewer than three and not more than five lay members appointed by the Crown with a full-time chairman and such staff and secretariat as may be necessary to permit the Board to carry out its functions; and that professional statutes be amended to impose an obligation on individual colleges, as Divisions under the Board, to accept and obey the rulings of the Board.

(7) That with a view toward bringing not only the health professions but all professions in the province within the purview of public supervision, the Government of Saskatchewan continue to study and monitor the passage, experience, and results of Bill 250 in Quebec, and initiate early discussions with representatives of all of the major professions in Saskatchewan outside of the health field as to the desirability and feasibility of establishing in Saskatchewan a general regulatory body over all of the professions similar to the Professions Board currently proposed for the Province of Quebec.

(8) That the Government of Saskatchewan, after review by the Health Disciplines Regulation Board, amend or abolish restrictive provisions of professional acts which define narrowly the scope of practice of the various health professions, and in particular, the narrow definition of the practice of medicine under Section 69 of the Medical Act.

(9) That in order to encourage and facilitate the development of the "health team" and the broadest application of the skills of allied health personnel so that public access to health services may be facilitated, no prosecutions be initiated against health practitioners for violations of the Medical Act without the prior written consent of the Health Disciplines Regulation Board acting as the agent for the Minister of Health.

(10) That existing legislation be amended so that no individual health occupation or discipline can come under the control of another discipline or profession; all individual health disciplines and professions should become separate Divisions of the Health Disciplines Regulation Board.

(11) That the Government of Saskatchewan should amend or abolish provisions under various professional Acts stipulating that members of individual professions may not be employed by institutions or agencies other than members of their own professions so that various practitioners, including pharmacists, optometrists, chiropractors, and chiropodists, can become colleagues and integral members of the health team in community health centres.

(12) That the Government of Saskatchewan should pass new legislation, consistent with the recommendations of the Hastings Report, providing for a new community health centres Act, establishing such centres with legal status so that they may accept collective responsibility to patients and to the community for the provision of health care through team practice.

(13) That the Health Disciplines Regulation Board undertake an extensive review of existing barriers to the "upward mobility" of various levels of practitioners; that the HDRB, after performing this review, consult with the Department of Health and the Departments of Education and Continuing Education, as well as with representatives of the provincial University, and then proceed to make recommendations to the Lieutenant Governor-in-Council, and to the various professional Divisions under the

Board, as to how best to overcome obstacles to the educational and professional advancement of able and experienced personnel within the health care system, either through continuing education programmes or through the admission of personnel, experienced at one level, to orthodox university and/or college courses at a higher level.

(14) That after one year of its existence, the results and experience of the Health Disciplines Regulation Board, plus the results of new institutions for professional regulation in Quebec under Bill 250, be used as the basis for judgement by the Government of Saskatchewan as to whether the province should create a Saskatchewan Professions Board to extend the principle of closer public regulations to all professions in the province.

PART IV

REGIONALIZATION

IV. REGIONALIZATION

1. The Case for Centralization

Certain functions of the provincial government *must* be centralized. As indicated in Part I, it is desirable and probably inevitable that the general Allocation of Resources function will be centralized in the hands of the Cabinet.

Under our parliamentary form of government, it is idle to argue either that "centralization is always good" or that "de-centralization is always bad". As indicated in Part I, the real question is *which* services can and must be centralized, and *which* services can effectively be de-centralized? The contention in this paper is merely that *Operational Services* of the provincial government can be and should be de-centralized. That the provincial government must remain responsible for the Allocation of Resources function seems beyond dispute.

The case for centralization is quite simple; it is also cogent.

- It can be argued that Canada is already over-governed, and that the interposition of a new and extra level of government may be expensive and superfluous.

- Centralization is administratively simple and convenient.

- It may be easier to control, integrate or "rationalize" the system through centralization, and cost control may be more precise.

- With centralization it is easier to focus and locate *responsibility*; no intermediate agencies deflect public attention from the ultimate responsibility of the Minister.

- Creation of decentralized units or regions may conflict (or appear to conflict) with existing *Municipal* boundaries and interests. Conflict with municipalities may create a dangerous political backlash hostile to the provincial government.

- Regions or decentralized units may become additional *pressure groups* making constant demands on the provincial government for more money.

- *Talent* is always scarce, and there may be insufficient talent to provide leadership and staff for regional units.

- Moreover, civil servants may be extremely reluctant to leave the provincial capital and interrupt their career patterns by entering service at the regional level.

Thus it is apparent that centralized arrangements may be more familiar, convenient, and tidy, and may provide the provincial government with more certain and direct control over the resources under its jurisdiction. Centralized arrangements have the advantage of being simple.

2. The Case for Regionalization

The case for regionalization is essentially a case for de-centralization and participation, and that case has been set forth in some detail in Part II. It may be argued that de-centralized services are more accessible and more responsive to the needs of individual citizens in their local communities. Through regional arrangements, de-centralized institutions may bring public services closer to the people at the local level and make government more readily understood by, and responsive to, the needs of the citizens. Such de-centralization might increase the direct involvement and participation of individuals.

A de-centralized system of regional boards could provide a buffer between the rulings of the relatively distant provincial government in Regina on the one hand, and the potentially unrealistic or unrestrained demands of local towns or villages on the other. It might be possible for regional boards to assist in the integration of services provided at the local level and possibly to effect certain economies, e.g., through bulk purchasing or through elimination of costly overlapping and duplication of services within a geographical area. However, it is possible that these economies could be achieved as well through more determined efforts by a centralized administration.

Regional administration might tend to break down large, monolithic bureaucratic structures at the provincial centre and make the processes of government more flexible. Local people may be better informed about and more sensitive to local needs and local problems as well as to unique community preferences concerning ways of doing things with regard to particular populations.

Regional structures may permit flexibility and variation in the application of public policy and public services to reflect special needs and preferences within a particular area. De-centralized regional arrangements might also bring an end to the assumption that the central administration in Regina knows best and must retain ultimate control and authority.

Thus the case for regionalization and de-centralization rests upon the premise of increased community involvement and participation. Regions may be effective in bringing about community action, politicization, and the fostering of direct community control over public services. If it is granted that there is a growing need for increased popular and consumer participation in the determination of public services, as argued in Part II above, particular de-centralized mechanisms are required for the activation and involvement of the people toward the goal of self-help, and the relatively small region is more likely to accomplish this

end than is the central mechanism of the provincial government or department. Community self-help and involvement will not occur spontaneously; the creation of community health centres as recommended in the Hastings Report does not guarantee democratic participation or local control, and the ultimate success or failure of community health centres may depend upon direct local involvement of the people most immediately concerned.

Saskatchewan's experience reveals several precedents for de-centralization. The 1944 Saskatchewan Health Services Survey Commission, headed by the late Dr. Henry Sigerist, not only anticipated the recommendations of the Hastings Report by three decades through its proposals for rural health centres, but also recommended a de-centralized system of Health Districts and argued: "There can be no doubt that such a de-centralization of activities will greatly increase the efficiency of the public health and medical services, while the principle of centralized direction will be maintained". There are precedents in the existing Public Health Regions and regionalized Psychiatric Services, but so far, regionalization in Saskatchewan appears to be more a theory and a paper design than a reality.

There is also the precedent of the Swift Current Health Region which has been in existence since 1946. It

is unfortunate that the successes and failures of the Swift Current Health Region have not been studied and evaluated by research during the past two decades. The fact that the Swift Current region declined to become a part of the Medicare Scheme in 1962 strongly suggests the relative satisfaction of this regional population with its existing arrangements, but at the same time there is little or no evidence that this regional arrangement has either reduced health costs or significantly increased public participation and involvement in the delivery of health services.

The case for regionalized de-centralization can be strengthened by a consideration of which particular public services might be rationalized and made more efficient through regional structures. On the basis of experience in Saskatchewan and elsewhere it seems apparent that hospital facilities, laboratory facilities, Public Health Services, and Psychiatric Services exemplify areas of public policy readily amenable to regionalized arrangements.

It may also be argued that social services generally should be delivered on a regional and integrated basis. Rural populations always experience unusual difficulties in obtaining fair access to public services. It is often inconvenient and exasperating for rural people to make separate trips to a town or village at different times, or

to different towns, in order to obtain information or access to health care, educational services, and social welfare services. It seems obvious that rural populations might benefit significantly from the better integration of social services through regional arrangements which guaranteed the possibility of access to various services in a particular town at one and the same time. Regionalized administrations might be more aware of, and responsive to, the need of rural populations to achieve access to a total package of public services at the same place and on the same day. Thus it may be possible for regional arrangements to increase the convenience, quality, and accessibility of public services.

Consequently we must distinguish between *single* service regionalization or Health Regions on the one hand, and integrated *multi-service* regions or health, education and welfare regions on the other. Of course it would be possible to create simple Health Regions,but this would defeat the general purpose of effecting an increased integration of Operational Services at the local level.

The preference expressed here is for combined health, education and welfare regions and the integration of public services at the local level which would obviate any short-run

necessity of merging existing provincial departments. One of the clear conclusions derived from experimentation in the U.S. with "neighbourhood health centres" during the past decade is that community programmes must be broader than mere health programmes. If local social service centres are to facilitate and legitimize access to public services for declining communities and disadvantaged citizens, then they must include far more than simple health facilities. To improve the quality of rural life, citizens demand increased access to a total package of public services. An aroused population involved actively in a local health centre or social service centre will want to talk and to act not only on matters of sanitation and disease, but also on matters of housing, employment, nutrition, welfare payments, education, and pollution - all related to health in the broadest sense of the word.

3. A Semantic Confusion and a Warning

A review of the available literature has led this writer to the conclusion that most of the contemporary material on regionalization is by no means appropriate or applicable to a province such as Saskatchewan. It must be emphasized that the scholarly writings on this subject, and

most of the current proposals for the creation of regional structures, emanate from eastern sources; they reflect biases and assumptions related to highly urbanized and heavily industrialized conditions of population concentration. Some of the new social service regions in Quebec, for example, are likely to include populations of one or even *two million* people. Proposals made by the Ontario Council of Health in 1970 contemplate regions equally large or larger. It is sobering to reflect on the implication that, in these terms, the Province of Saskatchewan might comprise one single region!

Therefore, a strong note of warning should be entered at this point. Proposals for regional schemes appropriate to provinces such as Ontario or Quebec may be totally inappropriate for a province such as Saskatchewan with its smaller and more geographically scattered population. There are real and significant reasons why Saskatchewan should proceed toward regionalization only with great caution.

In recent years, with the growing pressure toward de-centralization of services and increased public participation and involvement, the assault on centralized departmental administration has been seen as a "good thing", and de-centralization has been taken to be synonymous with, or

assumed to be identical with, regionalization. This view may be an over-simplification at best, or indeed misleading. *"Regionalization" is by no means synonymous with "de-centralization".* De-centralization of operational public services is desirable, but it is by no means clear or certain that a scheme of regionalization necessarily would achieve this end. In fact, certain types of regional arrangements might well increase centralization.

The concept of regionalization is an exceedingly complicated one, and no single writer pretends to have all of the answers in this field. It is significant that several recent governmental reports have urged the principle of regionalization in some form, including the Castonguay Report in Quebec, the Report of the Committee on the Healing Arts in Ontario, and the federal Task Force Report on Health Costs. However, these reports agree more on the principle of de-centralization than on any precise methods of creating regions. Whether regional structures actually achieve de-centralization depends very much upon the functions to be performed by the region and the degree of independence or autonomy to be granted to the regional authority.

In the Saskatchewan context, a valuable paper by Mr. M. B. Derrick, dated May 1970, reminds us that "regionalization is a division of a political entity into geographic

regions to provide a service or services with better quality and/or less cost". As Mr. Derrick points out, there are three principal organizational alternatives to consider:

- One that plays an advisory role only;
- One that is created to further the administrative efficiency of a central authority;
- A Region that has executive authority and a considerable degree of independence and autonomy.

These are the clear alternatives, and it seems evident that only the latter arrangement, providing for a degree of autonomy, offers any real hope for true de-centralization in terms of the participatory principles outlined in Part II of this paper. However, as will be argued below, it is highly unlikely that regional schemes providing for popular participation and involvement would necessarily reduce total costs significantly. In fact it is likely that schemes for regionalization would increase total costs to the public treasury.

In general we might formulate the rule of thumb that the larger the regional unit, the greater the efficiency and cost reduction is likely to be; conversely, the smaller

the region, the greater the degree of public involvement and participation is likely to be. In other words, there appears to be a significant trade-off between direct public and community involvement on the one hand, and cost-efficiency on the other. Therefore, decisions concerning the size and structure of regional units may have to represent a compromise between different optimal populations appropriate for cost efficiency as versus popular participation. Moreover, optimal units of regional size may be different for health regions, educational regions, and for social welfare or social service regions.

These problems should be borne in mind as we consider current approaches to regionalization in other jurisdictions.

4. Approaches to Regionalization in Ontario

In recent years the pace of change in health care delivery systems has been so rapid in several Canadian provinces that it is difficult to keep abreast of current developments. Both of our largest provinces, Ontario and Quebec, have recently undergone significant changes which may reveal instructive lessons for other provinces eager to press on with innovation. The following pages will attempt a brief review of recent developments in Ontario.

On August 22, 1972, the Ontario Minister of Health released a new plan for the "Re-organization of the Ministry of Health". The document outlining the plan asserts that it is aimed at integrating health services, introducing innovations, and cutting costs. The scheme is complex, and the Minister has stated that at least five years will be required to implement the scheme. Prior to the announcement of this plan, the hospital insurance scheme and the medical insurance scheme had been discontinued as separate Commissions, and had been united into the Ontario Health Insurance Plan (OHIP); administration of OHIP has been brought directly within the departmental structure. The Department itself has been re-organized into three new branches. This re-organization is based upon a scheme outlined by private commercial consultants working in conjunction with the Ontario Committee on Government Productivity.

Whereas the old organization of the Ministry was derived from three major program areas, namely Health Promotion and Disease Prevention, Treatment and Rehabilitation, and Psychiatric and Retardation Services, the new organizational format calls for the creation of three new and different major divisions within the Department.

First, there has been created a Health Standards Division which sets criteria and standards for personal

and institutional care as well as for environmental health, and is responsible for all research, planning, and evaluation of both new and existing programs.

Second, the new Health Services Division is responsible for the implementation of comprehensive health care programs throughout the province. This division administers directly psychiatric and retardation services. The Health Services Division controls the "Area Planning Co-ordinators" who are intended to link direct provision of services by District Councils within the province to this Division of the Department.

Third, the new Finance and Information Services Division deals with all matters of finance, including payment for health insurance programs, and provides information to the public on specific topics related to health care.

Each of these new Divisions of the Ministry is headed by an Associate Deputy Minister. These three Associate Deputies have been designated as "the top management team" responsible, together with the Deputy, for "strategy development leading to policy formulation".

It may be too early to assess the results of this expensive and ambitious reorganization scheme. Such sweeping changes take time to implement. However, it is apparent

that many civil servants in the Department are extremely confused and unsettled by the plan, and the Department has undertaken an extensive educational program for middle management to explain and interpret the concepts underlying the new organization. Certainly it is intended that there will be much greater emphasis on the research, planning, and forward policy formulation functions than has been evident in the past. The Ontario Council of Health has been retained, reporting directly to the Minister, but it appears that the influence of this advisory body has been diminished. The Minister seems resolutely determined to run his own show. He is impatient with advice received from the Council of Health and with any suggestion of interference from above within the governmental structure. The province of Ontario has recently created several new policy fields with "Super Ministers" and "Super Deputy Ministers". The Super Minister for Social Development Policy is Mr. Robert Welch, assisted by a Super Deputy, Dr. Douglas Wright, whose functions are to coordinate long-range planning in the general fields of health, education and social welfare services.

As of June, 1973, it is apparent that most civil servants in the Department of Health are totally confused

and demoralized by the recent reorganization. Many outside observers believe that the reorganization scheme may be sound in theory, but possibly unworkable in practice in the short run. Morale is extremely low. Many civil servants appear perplexed, confused, and frightened by the recent changes, and extremely uncertain as to what their own individual roles and functions may be. The short-run result is that the Department now suffers from almost total chaos and paralysis. To put the most favorable possible construction on it, the new reorganization scheme (whatever its merits in theory) must be judged a mixed success at best or a short-term failure. At present, no other department in the Government of Ontario is in such a state of confusion.

There are several reasons for this. First, in recent months the Minister himself has been in hospital with illness, and at least one of the new Associate Deputy Minister slots was not filled. Thus there has been a lack of leadership and direction in the Department. Second, this extensive reorganization has been attempted at the same time as the Government of Ontario imposed general budget restrictions and inhibitions on the hiring of new personnel. Third, the existing personnel neither understand nor entirely

sympathize with the reorganizational scheme, and are fearful of their positions. Fourth, certain senior civil servants including the former Deputy Minister and an influential senior policy officer (Dr. David Kinlock) have been either "kicked upstairs" or demoted and caused to resign. Thus the circumstances surrounding the implementation of this new scheme have been awkward at best and it may be premature to assess its relative successes or failure, even though relative failure appears to be the consensus.

But there is also a fifth reason why the reorganizational scheme has met with extreme difficulty. This is because the scheme assumes and presupposes a regional or district structure for the delivery of health care services in the field. Quite possibly the importance of decentralized delivery units to the success of the Departmental reorganization was not entirely recognized by the authors of the scheme. This regional structure has not yet evolved, and it is by no means clear that the present Minister intends to encourage its evolution.

If we are to understand the development of regional health structures in Ontario, we must recognize that health care planning in that province has been in a state of flux, if not chaos, since 1970. The publication of numerous reports, the rapid succession of four Ministers, and the

abrupt removal of the former Deputy Minister in May, 1972, plus the creation of the "Super Ministry of Social Development Policy" for health, education, and social welfare have all combined to confuse the picture.

Since the publication in 1967 of the Report of the Ontario Committee on Taxation (the Smith Report) which advocated a very broad and inclusive scheme of regionalized government for the province, the Ontario cabinet has been groping without notable success toward the development of new and general regional arrangements. A principal stumbling block toward regionalization has been, between 1967 and 1973, the Department of Health. That Department has been sceptical at best in its attitude toward the principle of regionalization, and has often appeared out of step with other departments in the general thrust toward regionalization. The Department of Health appears extremely reluctant to become involved in regionalization schemes emanating from other departments, particularly the Department of Municipal Affairs where political backlash has been most evident. The Department of Health seems determined to go its own way and create its own separate regional structures experimentally and *very* slowly.

Like the Hall Commission of 1964 and the Federal Report of the Task Force on Health Costs in 1970, the Ontario

Committee on the Healing Arts (1970) recommended the establishment of health regions, but it failed to spell out what sort of regional scheme was envisaged. During the period 1970 until early 1972 in Ontario, most of the discussion of regionalization concentrated upon recommendations made by the permanent advisory body to the Minister of Health, the Ontario Council of Health. Supplement No. I of the Annual Report of the Ontario Council of Health, entitled *Regional Organization of Health Services* made detailed proposals for such a scheme. At pages 10 and 11, the Report outlined the objectives of the system: to achieve a balanced and integrated system of health care facilities, to improve distribution of services, to identify health needs, set realistic goals, and establish priorities in health programs and services within each area; to achieve greater cooperation with other areas of planning, to improve and strengthen needed existing services, to develop new health services and apply new knowledge, to eliminate unnecessary duplication, and to prevent fragmentation of health services at provincial and local levels.

The Ontario Council of Health recommended that there should be *two* levels of authority below the provincial level. The province should be divided into regions, and each region should contain several districts. Appointed councils

were suggested for each region and each district, with limited authority delegated to them by the province; the councils apparently were intended to perform mainly an advisory function.

There would be seven regions in the province, two in the North, based on Sudbury and the Lakehead, and five Southern regions each based upon a University Faculty of Medicine or School of Health Sciences. Considerable emphasis was placed upon university facilities as the nucleus and primary technical resource-base of each region; thus Toronto, Kingston, Ottawa, Hamilton, and London would be the centres of the five Southern regions. It was proposed that each University School of Health Sciences should establish throughout its region various satellite clinics, which would be in effect demonstration or pilot projects. These clinics would be geographically scattered to bring high quality service to impoverished areas and under-serviced rural districts. Both medical students and students of other allied health disciplines would spend part of their clinical training providing service in these satellites.

The Ontario Council of Health proposed that each region should have a regional health council providing representation for: a) the local district health councils, b) the

University Health Sciences Centre, c) local or municipal government appointees, d) other members of the public appointed by the Minister of Health.

The proposed membership of the District Councils was much less clear. Apparently it was intended that District Councils would include representation from professional and technical interests including hospitals, local municipal government, voluntary agencies and representatives of the lay public.

In the case of both the regional councils and the District Councils, their membership was to be appointed rather than elected.

In the following year the Annual Report of the Ontario Council of Health, 1971, repeated the emphasis upon the importance of regionalization and added some detail to the proposals, but the basic shape of the Councils' recommendations remained the same. There was still a stress laid upon basing regions upon University Schools of Health Sciences, inclusion of both the regional and district levels, districts to provide the basic units of health care for citizens in small areas, and planning to take place mainly at the regional level. It was clear that the provincial Department of Health should continue to control health standards and

policy, and to set guidelines within which regions would operate, while the regions would fulfill their planning function mainly in an advisory capacity.

By 1971 local initiatives in several areas of the province had resulted in the creation of voluntary district health councils, and such councils were active in Hamilton, Ottawa, Niagara, Thunder Bay, and Sudbury. These district councils appeared to have sprung up from the grass roots level with little or no guidance from the provincial capital. Their principal purposes were to assess local needs, to attempt to avoid waste and duplication of services, and to make recommendations to the provincial government concerning needs and possible innovations. The District Council in Hamilton appears to be one of the most successful of these institutions. The Hamilton council began initially as a hospital planning council and was gradually expanded into a health planning council with the addition of further members on a voluntary basis. Predictably, several of these councils, notably the Hamilton council, began to request from the provincial government formal recognition of their roles and some degree of executive if not financial independence and power. These requests seem generally not to have been heeded.

In Ontario as in other provinces, the appearance of the Hastings Report on Community Health Centres in August, 1972, served to quicken interest in de-centralized regional structures, but there appeared to be more enthusiasm for the Hastings recommendations on the boards of several district health councils than there was in the Department of Health in Toronto. As noted above, it was also in August of 1972 that the Department released its plan for the reorganization of its administrative structure. That reorganizational plan seemed to presuppose the existence of Districts to deliver services, and it would be at the district level that the three new branches or streams of the re-vamped Department would come together.

By the beginning of 1973, however, the picture became even more blurred. By that time the "re-organized" Department of Health was considerably demoralized and confused. Then too, in January of 1973 the Minister announced his intention to appoint "Area Planning Co-ordinators" for three areas: the north, the south-east and the south-west. In this announcement regions had disappeared. Area Planning Co-ordinators were to be the principal links between district councils and the Department. Area Co-ordinators apparently had little or no executive power, but merely hopeful capacity

to persuade. Each was to take responsibility for coordinating the activities of various Districts as they might exist within the "area", but with Regions then forgotten or pushed aside it was by no means clear how these Area Co-ordinators were to fulfill even their limited functions. The Minister's statement of January 1973 suggested that Area Co-ordinators should "relate to existing local structures". No one, including the Area Co-ordinators themselves, has yet been able to determine what might be meant by that notably vague phrase.

Thus it was clear that by the spring of 1973 the Department was floundering and the sketchy scheme for regionalization was in limbo.

It must be emphasized that the reorganization of the Department of Health, if it is to work at all, depends heavily and directly on the emergence of regional and/or district structures which have always been assumed to be the point of contact at which services are actually delivered in the field. Even in theory, the role of the Area Planning Co-ordinator has never been clear. Presumably the nascent district health councils were to relate to the Ministry through the Area Co-ordinator who was an appointed civil servant. It was intended that the Co-ordinator would ensure

that health objectives were appropriately established and achieved within each district, but he could not personally direct the activities or set the objectives of the individual district councils. Councils have no right of direct access to the Deputy or Assistant Deputy Ministers but must work exclusively through the Area Planning Co-ordinator as their sole point of contact.

To many critics of the scheme, this appears to be a major source of difficulty. The Co-ordinator has no real power or authority except in so far as he may be able to interpret to the Districts the general policies and guidelines of the Department. The Area Co-ordinators would have to exercise remarkable powers of persuasion, tact, and flexibility, but their executive power seems extremely uncertain and limited. Although the scheme could work while members of the District Councils are appointees of the provincial government, and thus possibly subservient to the wishes of the Department, it is extremely unlikely that the scheme could function smoothly with elected rather than appointed members on the Councils. While voluntary Councils might conceivably be willing to accept direction from Area Co-ordinators, the probability is that as District Councils become better established they will demand at least some degree of executive power and autonomy. Already there are

signs that certain of the District Councils, such as the one in Hamilton, are beginning to request global budgeting arrangements which would provide them with a degree of independence.

As yet no firm rules have been laid down indicating the composition or the functions of District Councils. In the Minister's announcements of August 1972 and January 1973, it was indicated that the composition of the Councils could vary in response to local conditions and requirements, but the membership would be appointed rather than elected, and it appears that "key people" would be appointed from each area. Membership on a District Council would include one representative of the physicians in the area, another representative for hospitals, others representing home care programs, nursing homes, and other existing health programs, plus four or five lay members representing the general public.

In the short run it was not intended that individual hospital boards would be eliminated, although some amalgamation of such boards would be encouraged. Provision was made that the Minister would have the power to take over or purchase any institution or facility providing health care, and that the Minister should have the power to appoint "one or more provincial hospital representatives" to any

hospital board; thus the Minister would have the power to intervene and to enforce almost any desired reorganization of health care services and facilities in any area.

Initially the role of the District Health Councils was intended to be advisory; they would not have executive power or financial authority. Their role would be to plan, coordinate and evaluate existing programs, and to make recommendations for change through the Area Coordinator to the Department. As of June 1973 the Minister has underlined his determination that the District Councils shall have no executive or financial authority at least until after they have proven their capabilities in planning and coordination. There is no indication that the Minister intends to permit real power to devolve upon the Districts.

Therefore, the experience in the Province of Ontario yields mainly negative evidence on the question of the viability of de-centralization. It seems reasonable to suggest that the reorganization of the Department is so far a failure, that the reorganization has inhibited the development of Districts, and that the failure of effective Districts to emerge and function has in turn contributed to the failure of the departmental reorganizational scheme.

There has been a growing public and professional awareness in Ontario that health planning arrangements in

the province are chaotic and paralyzed. Recognizing this unhappy situation, the Ontario Hospital Association and the Ontario Medical Association in May 1973 took an extraordinary initiative. They issued a joint policy statement on behalf of the two associations representing some 250 hospitals and 12,000 physicians in support of the general concept of District Health Councils. Their joint statement, however, stresses that the creation of such Councils should not be imposed on communities by the Department. In a press release carried in both the Toronto *Star* and the *Globe and Mail* for May 10, 1973, the OHA and OMA stated: "We would prefer to see the impetus for the Councils come from within the districts themselves, and have them utilize as much as possible the framework already created by existing planning councils." Clearly they were concerned that planning should proceed from the bottom up, and fearful that planning might proceed from the top down and be imposed arbitrarily on them. The joint statement went on to say, "It is essential that not only must all council recommendations be given due consideration by the Ministry, but also no decision regarding a district must be made by the Ministry until the council has been consulted and had an opportunity to comment on it. Until this principle holds, we see no future for District Health Councils."

(Students of politics may observe that this is sound Maoist doctrine, involving a two-way flow of consultation, both up and down.)

The president of the OMA seemed particularly uneasy over the possibility that general regional structures in the province would cut off physicians and District Councils from direct contact with the Ministry. The president of the OMA was quoted as saying: "One aspect on which our Association feels most strongly is that District Health Councils ... should be responsible directly to the provincial Ministry of Health rather than to any level of regional government."

Both the OMA and the OHA expressed a strong preference for appointed rather than elected District Councils. The two groups urged that the Councils be made up of 15 members, including four representatives of the lay public, two each from district hospitals and local medical societies, and one each from local government, allied health professions, voluntary health and social welfare agencies, district medical officers of health, extended care and home care institutions.

In fairness we should note that no one has ever pretended that the emergence of District Health Councils could be a quick or simple matter. Such institutional

arrangements must evolve slowly, and the growing pains are necessarily acute and prolonged.

At the time of writing it would be folly to hazard predictions as to future developments, but few observers in Ontario are optimistic at this point. In the absence of strong leadership from the top, and in the absence of established community health centres at the bottom, it is extremely difficult for the middle or regional level to evolve and crystallize, particularly without firm guidelines laid down by the Department.

In short, there is no reason to believe that Ontario can be taken as a model for other provinces to emulate. The lessons to be learned from that province are mainly negative, and there is little prospect in the short run that the Ontario Department of Health will be able to overcome its existing difficulties successfully. It may well be that other jurisdictions have more to learn from the experience of Quebec than they have from Ontario.

5. Approaches to Regionalization in Quebec

It is clear that the Report of the Commission of Inquiry on Health and Social Welfare, Quebec, 1970, often called the Castonguay Report, is one of the most important

social documents in this field of public policy. With the completion of the preliminary volumes of the Report, M. Castonguay entered the Cabinet. As the minister responsible for the implementation of his own Report, Castonguay obviously intended to carry out very sweeping reforms in the Province of Quebec. In December of 1970 the former Department of Health and the former Department of Social Welfare were combined into a *single Department* of Social Affairs. Since that time at least two major pieces of legislation have been promulgated by the new Department: Bill 250, providing for increased public regulation of the professions, discussed in Part Two above; and Bill 65 which created a radically new system of regionalization for health and social services, a system which was effectively established by January, 1973.

Bill 65 establishes *twelve administrative Regions* in the province. Each Region is governed by a "social affairs bureau" providing for representation and participation by both practitioners and consumers.

Within each Region, various types of *Centres* are being established at the local level. There are four types of these units:

(1) Local Community Service Centres, designed gradually to replace emergency service units of hospitals, and intended to provide a very broad range of ambulatory health and social services;

(2) Hospitals, now to be called "hospital centres", including several levels of acute care and convalescent hospital institutions;

(3) "Social Service Centres", providing social action services to persons facing psycho-social difficulties, and providing foster homes, mothers' helpers, consultation, diagnosis, psycho-social treatment, placement or adoption services;

(4) "Reception Centres", including day care centres, rehabilitation centres, and "night care centres", designed to assist, lodge and support those who by reason of physical, personality, psycho-social, family, or age reasons must be treated or kept in a protected residence.

These four types of Centres will be administered under a regional Bureau in each of the twelve regions. The Bureau will have a provincially-appointed administrative officer plus a membership of twenty individuals appointed for three-year terms. The full composition of each Bureau includes the following appointed representatives: two from universities, three from local service centres, three from hospital centres, three from social service centres, three from reception centres, and six representatives of "socio-economic groups" within the region. Of these

twenty members, four will be selected as an Administrative Committee which, together with the Administrator, will supervise the day-to-day affairs of the Bureau.

Bill 65 also provides that each of the four types of Centres will have a Board of Directors, one-half of which will be elected by the people served by the Centre.

For example, the Board of Directors of a "local service centre" will consist of ten members, half elected directly, and half appointed. Of the ten members, five will be elected for terms of four years, one will be appointed by the Bureau for a two-year term, one will be appointed by professionals practising through the Centre, one will be appointed by hospital trustees, one appointed by Boards of "social service centres", plus one provincially-appointed General Manager for the Centre.

Similarly the Board of Directors of a "hospital centre" and a "social service centre" consists of fourteen persons selected as follows: seven members (or half of the Board) appointed by the provincial government for four years after consultation with the appropriate socio-economic groups in the area served, two persons appointed by the Bureau, a person appointed for two years by the council of physicians and dentists practising in the Centre, a person elected for two years by the professionals practising in the Centre, a

person elected for two years by all members of the staff of the Centre, a person appointed by the Board of the local "community service centres" in the area, plus a General Manager.

Budgets for all four types of local Centres must be submitted for approval to the regional Bureau. The Bureaux in turn must submit annual budgets to the Minister for his approval, plus a "rolling" five-year budget plan indicating future expenditures. All budgets must be approved by the Lieutenant-Governor in Council.

Initially it was M. Castonguay's intention to make provision for lump-sum or "global" budgets for each region. However, a global budgeting scheme has not yet been implemented. This fact appears to indicate some shift of opinion or possibly disappointment with the results of the regional scheme.

Clearly M. Castonguay was "going for broke" with a sweeping program of rapid innovation, creating regions throughout the province within approximately a twelve-month period, with the purpose of bringing about de-centralization and real popular involvement. Considerable doubt has now emerged in Quebec as to whether the scheme has in fact resulted in a significant degree of popular participation. Given the extreme rapidity with which the scheme was imple-

mented, this shortcoming is understandable, but the strong feeling persists that the government has bitten off more that it could chew within a short time. Evidently the initiative for reform has come from the top down, rather than from the bottom up; consequently some people feel that the government has effected change through a "cookie cutter" which has been imposed upon the people in the form of a rigid plan.

Moreover, senior officials of the Quebec Department of Social Affairs recently have indicated several of the problems encountered with the scheme. At the April, 1973, annual convention of the Canadian Public Health Association, C. E. Forget, an Associate Deputy Minister in the Department, delivered a paper on regionalization in Quebec in which he observed that it may be a long time before the Regions are granted any significant degree of independence or autonomy; global budgets are not likely to be used in the foreseeable future. Furthermore, M. Forget suggested that, in effect, the scheme has resulted not in highly de-centralized structures, but rather in the creation of a very highly centralized system. He also suggested that the great bulk of appointees to the Regional Bureaux and to the Boards of local Centres have been physicians or other professional

allied health personnel, not laymen. Thus there is reason to believe that the Castonguay reforms have resulted in the creation of a scheme which is both (a) highly centralized and (b) professionally dominated. Genuine popular participation has been very slow to emerge, and the Bureaux are restricted, in effect, to a role that is merely advisory.

But there is one other point which requires heavy emphasis. In Quebec as in Ontario, the government is extremely -- and understandably -- unwilling to grant financial autonomy to regions until AFTER existing Dominion-Provincial financial disputes in the field of health are resolved. Until provincial Ministers of Health can gain greater control over revenues, and the right to distribute health care funds without federal restrictions, they will not make regions financially autonomous. If they did, those Ministers would suffer a very serious loss of control, and would be reduced to the unenviable role of a mere "post office" between Ottawa and the regional units. Therefore, true de-centralization must await the day when Ottawa changes its mind on financial arrangements.

6. Recent Federal Proposals

The Report of the Task Force on the Cost of Health Services in Canada (1969) endorses the principle of regionalization for health services, but the more recent Hastings Report on Community Health Centres (1972), by contrast, appears to place greater emphasis on District, local or community control of the health care system.

The Task Force Report on the Cost of Health Services recommended the creation of health planning regions whose purpose should be to advise provincial governments as to goals, priorities, and effective coordination of services within a given area. The Task Force recommended that regional boards should be concerned with hospitals in the first instance and expand their scope to health services somewhat later, but should retain an advisory function only. This Report proposed that no changes in physical facilities or services should be undertaken without the prior review and recommendation of the regional board, and that such regional boards should recommend not only new or expanded facilities, but also the conversion to alternative use or possibly the closure of existing facilities, including hospitals. (See Task Force Report, Vol. I, pp. 19-22.) The Task Force also recommended (Vol. II, p. 9) that

regional boards should be composed of representatives of hospitals, doctors, municipal authorities and the public. It was evident that the Task Force intended the regional boards to prevent costly duplication of services and to recommend elimination of such duplications and/or closure of redundant units including small hospitals.

It should be noted that this Report explicitly recommended against the creation of an additional administrative level in the provinces. The regional boards were assumed to have advisory functions only, and the regions were very large, stipulated to include some five hundred thousand people. Again, in these terms, the Province of Saskatchewan might include two regions at most.

But the Report of the Task Force on Health Costs has been largely superseded by the publication of the Hastings Report in August of 1972, a document which has been endorsed "in principle" by all of Canada's Ministers of Health at a conference in May, 1973. As indicated above, the Hastings Report on Community Health Centres assumes a sharp reduction in Canada's total hospital bed capacity. It assumes a real and deliberate shift of emphasis from hospital care to ambulatory care, and the substitution of community health centres emphasizing multi-discipline team practice in each

community. Close involvement of the people in the administration and delivery of health services is assumed, with the base population of a community health centre being between six and nine thousand people depending upon specific circumstances. It is further assumed that twenty-four hour service will be provided and that community health centres will be the focus for a very broad range of public involvement and social action programmes. The Hastings Report proposes global budget arrangements for each community health centre, alteration in the method of payment for health service personnel, and the provision of a wide range of social services as well as health care through the local centres.

The Hastings Committee believes that the provincial government must retain the major responsibility and the ultimate control over planning, allocation of resources, and evaluation of health services. They also propose that the provinces must be prepared to delegate to the district or area levels of administration, subject to basic provincial guidelines, sufficient autonomy and responsibility to ensure that local needs are recognized and met. The precise size or population of a health District is not specified, but it appears (in appendix B) that District administration might include a population of fifty thousand in an urban area

or some ten thousand in a rural area.

The Hastings Report proposes that the District administration must be responsive to, and representative of the general public and facilitate the broadest possible public involvement.

The District administration should have authority over the detailed planning and establishment of priorities for health services and budgetary requirements, as well as the location of community health centres in the area. On a global budget basis, the District board should allocate funds to the various services and institutions under its jurisidction.

The Hastings Report recommends that on each District board there should be participation of citizen organizations, voluntary agencies, municipalities, and the provinces. Professional and practitioner representation should also be provided for. The interests of significant minority groups should also be represented on District boards. Each board should be assisted by a "technical advisory committee", made up of professional personnel, to advise on technical and professional questions. While each individual District is to be administered by a broadly representative board, the question as to whether each individual community health

centre should have a board is left open. "If a board can serve useful purposes then it should be established; in other instances these purposes may better be fulfilled by the District or area board." (p. 43.)

In spite of the undoubted excellence and importance of the Hastings Report, here again we see the general tendency toward emphasis on de-centralization and popular involvement, but an absence of specific clarity as to how either de-centralized or regional arrangements are to be carried out. It seems that the Hastings Report does not propose any interposition of a regional structure between the small Districts and the local community health centres on the one hand, and the provincial government authorities on the other. The term "regionalization" scarcely appears in the Hastings Report; instead, the heavy emphasis is placed at the District or local and community level. It is also significant that the Hastings Committee recognizes the importance of provincial control over allocation of resources and the establishment of provincial guidelines to assist in the development of community health centres. These facts appear to reflect the growing current scepticism and caution on the part of many authorities toward the creation of intermediate levels of administration or regional structures.

7. The Proposed Scheme for Saskatchewan - COMMUNITY HEALTH CENTRES

The foregoing review of health policy initiatives in other jurisdictions leads inexorably to the conclusion that the main thrust of provincial health policy should be toward the rapid creation of community health centres. It is significant that local "centres" will form the basic cells and focal points of the reformed health care system in Quebec; that the province of Ontario has de-emphasized the regional concept and indicated its intention to stress the integration of services at the local and District level; and that the Hastings Report has also underlined the crucial importance of the development of community health centres.

In the light of contemporary research and thinking, it seems apparent that the major goals of provincial health policy must include:

(a) broadening the distribution of, and increasing public accessibility to, health services of high quality;

(b) restraint of total health costs through the gradual substitution of the skills of allied health personnel for scarce physicians' skills and the development of the health team, as well as the gradual substitution of ambulatory clinical facilities for more expensive hospital care.

(c) increased involvement and participation on the part of consumers and the lay public in the shaping of the health care system.

While of course there are no simple panaceas which will bring about over-night a health care utopia, it is obvious and significant that the one institutional arrangement generally accepted as most likely to achieve all of the three above goals is the community health centre.

The Hastings Report defined a community health centre as:

> ...A facility or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality. Such care must be provided in an acceptable manner through a team of health professionals and other personnel working in an accessible and well-managed setting. The community health centre must form part of a responsive and accountable health services system. In turn, the health services must be closely and effectively coordinated with the social and related services to help individuals, families, and communities deal with the many sided problems of living." (p. 1.)

The Hastings Committee, a broadly representative group of practitioners, scholars, administrators and laymen, emphasized that community health centres "are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities, and relationships which society

wishes to establish for health care in the future". The Report acknowledges that it would be "foolish" to pretend that community health centres can cope with or solve all existing problems, but they state that such centres "can have an impact on costs and the rate at which costs are escalating as well as going a considerable way towards reducing fragmentation and duplication of services. They can make better use of resources in providing health services to people, and do offer a means of better coordinating health services with social services. In the area of wider public policy, we feel that the federal and provincial governments now realize they must do more than simply pay the bills. They must assume an effective leadership role." (p. 18).

Community health centres could be designed to provide health care only, and could conceivably neglect the provision of other related social services. In some eastern and heavily concentrated areas of urban population, a strong case might be made for using local centres for the provision of health care only, until such a time as they may be well established. However, in the context of Saskatchewan, with its more widely scattered population and the more difficult access of rural people to public services generally, it is highly desirable that such centres should provide the

broadest possible range of health and social services if the quality of rural life is to be improved.

Accordingly, it is proposed that community centres should provide not only health care but a broad spectrum of integrated social services. In the Saskatchewan context, community health centres might better be called Community Development Centres (CDC) and include education and welfare or social services in addition to health facilities; these Centres should be seen as the local focal points for the delivery of operational public services generally, and thus should be styled Health, Education, and Social Services (HESS) agencies. They should provide for the effective integration of the operational services of various departments at the community or field level.

Therefore, Community Development Centres (CDC) should provide the following services:

- *Health care services*, including the services of physicians, allied health personnel, and support staff, as well as ambulatory mental health care;

- *Welfare and Social Services*, including distribution of welfare payments, home care, and the coordination of voluntary associations;

- *Education services*, particularly as a local base for the coordination of "non-school programmes", including adult education, public health education, manpower re-training programmes, and university

and college extension programmes, as well as a field base providing health disciplines training programmes, medical and non-medical, so that students of the health sciences may be exposed to the realities and benefits of team practice in a community health centre setting, and so that attitudes of such personnel may be changed in the educational process (compare Hastings Report, p.26). Thus the Community Development Centre can be regarded as the focal point for a two-way street involving the education of both practitioners and the community.

- *Office space and services*, for existing health practitioners, Public Health personnel, and various voluntary agencies.

- *Information Services*, disseminating information relating to all operational services of government and HESS programmes.

- *Complaints and Grievance services*, to receive, screen, advise on and act upon complaints received from the community.

Generally CDCs would provide a local focus for a broad variety of community action programmes. It is anticipated that the CDCs will be regarded by the community and by the government as focal points for community action programmes of various kinds and for many types of community self-help. At this stage, it would be undesirable to define or delimit the possible scope of such community action. Individual communities may decide to invite, or provincial governments may decide to offer the services of, personnel trained and experienced in matters of assisting local populations

to organize and help themselves.

If significant forms of 'participatory democracy" are to evolve at the local level, it is natural and desirable that these forms of local action should seek expression through the Community Development Centres. Experience in the U.S. with neighbourhood health centres suggests that, to quote Dr. P. G. Stensland, "centres will have to concern themselves not only with cure and care, but with seemingly extraneous matters like community pageants, crime, single-parent families, jobs, effective communication, drug addiction, illiteracy. Health centres have to become what Elinson calls 'politically acceptable conduits for funds to be used for purposes far beyond the mere provision of health services'. Health will have to become the entrance to community action and pave the way toward effective citizenship." (Stensland, unpublished paper delivered to CPHA, June, 1972.)

In this connection it will be necessary for the provincial government to decide whether "community activators", will be made available to individual Centres in various localities through either the Department of Health, or Department of Social Services, or perhaps through the Department of Human Resources Development which already has

some experience in the promotion of community action. The government might also give consideration to reviving the former university Institute for Community Studies, not merely for research, but also as a stimulant to action programmes and to give support to local Community Development Centres.

The *Structure* of Community Development Centres will require the full-time management of an Administrative Officer appointed by the province on the recommendation of the Board of Directors responsible for the Centre. The size of population served by each Centre, and the range of services provided, will determine whether each CDC will require a separate individual Board, or whether a Board of Directors for a District would suffice to oversee and guide the affairs of the Centre. The Board should comprise both appointed and elected representatives of the public, including professional practitioners, allied health personnel, and laymen; lay representation should include appointees of existing local or municpal institutions, plus members elected by "users' committees" providing special representation for members of disadvantaged groups (see above, part II, section 5).

Control and budget of the Community Development Centres should include provision for a significant degree

of local autonomy in budgetary arrangements and the provision of lump-sum or global budgets to the Centres. CDCs should operate within policy Guidelines set forth initially by individual departments, and later by a Cabinet Co-ordinating Committee for Health, Education, and Social Services. Global budgeting is an important principle if local involvement is to be achieved. Representatives of the immediate community should have some latitude concerning decisions as to what areas of social service are to be emphasized and how limited quantities of public funds are to be allocated to individual communities. Precedents already exist for the allocation of global budgets to the three existing community clinics in Saskatchewan.

Low interest loan capital may have to be provided by the Province to facilitate the creation of Community Development Centres. Presumably all of the provinces of Canada, in the light of the recommendatios of the Hastings Report, will unite in demanding expansion of federal funds for the establishment of community centres. Existing federal "Thrust Grants", which must be increased, should be applied by the province mainly to the fostering of CDCs.

CDC budgets must be submitted annually to, and approved by, the Minister of Health and/or the appropriate

Cabinet Co-ordinating Committee. These budget submissions may be channeled through the appropriate Regional authority if such structures are created (see section 9 below). Budget submissions should also include a "rolling" five year plan outlining anticipated future levels of CDC expenditure.

Staffing: For most CDCs, staffing may not be a major problem. It will be important to achieve not only integration of HESS field staffs, but also an appropriate mix of various skilled health practitioners, including physicians, physicians' associates, nurses, optometrists, chiropractors, clinical psychologists, etc. A true health Team must emerge.

Ideally a CDC should have at least THREE physicians providing services through the Centre, thus making allowance for night and weekend coverage, holidays, and absences for continuing education programmes.

In smaller Centres, where *no* doctor is available on a resident services basis, use will have to be made of visiting practitioners, physicians' associates, nurse practitioners, and a system of ambulance services to transport patients to larger Centres or hospitals.

Incentives are always important in the creation of new institutions. In order that the CDCs may attract and

hold high quality medical staff, it will be necessary to offer inducements and demonstrate real advantages to the medical practitioner rather than to command his services through the rigid demands of public policy.

Inducements may include: clear acknowledgement that the M.D. is to be the leader of the health care team, and that the physician will have a clear and direct voice on the CDC Board; demonstration that allied personnel and support staff will be able to relieve the M.D. of various time-consuming tasks for which he is over-trained; guaranteed minimum income, either through salary, capitation, or salary plus fee-for-service arrangements (there is no intention here of significantly reducing medical incomes); generous arrangements for release time, including holidays, sabbaticals, and study-leave time; increased opportunities for both continuing education and research work, particularly in epidemiology. Incentive bonuses might also be offered to CDCs which achieve economies through lower hospital utilization rates, returning a portion of the money saved to the Board of CDC.

Costs: Creation of the CDCs will involve capital and other costs. There is no reason to believe that CDCs will bring about financial savings to the public in the short run, but in the long run it is anticipated that

reduced hospital utilization rates will bring about real savings to the public treasury.

With regard to costs, several rules of thumb should be applied: Global budgeting for CDCs is preferable to open-ended programme financing; the substitution of paramedical for medical services is often desirable; in areas in which physicians are not available, circumstances may require the closing of some small cottage hospitals and the substitution of Community Development Centres; the more voluntary agencies that can be involved in providing service, the better; the more CDCs can succeed in substituting ambulatory clinical services for hospital care, and the more home care provided, the better.

It should be emphasized that in large measure the CDC concept, as recommended in the Hastings Report, rests upon the substitution of clinical services for more expensive hospital care. Any decrease in hospital costs would be a boon to the taxpayer. It is also important to note that CDCs may also provide expanded local opportunities for public investment to be pumped into dying communities - real investment in People and Services. With their provision of an integrated package of public services and their substitution of multi-discipline team practice for the services of a single over-worked physician, the creation of

Community Development Centres may also assist in raising the standards of public services provided, in restraining rural population decline by expanding public investment, and in expanding non-farm employment opportunities (compare the Manitoba "Stay Option", above, Part I, section 6).

It is anticipated that there will emerge important relationships between the *CDCs and the University*. There is little use in fostering multi-discipline team practice in CDCs if medical students remain uninformed about the advantages of ambulatory clinics and various forms of group practice, or if the training of medical students leaves them ignorant of the potential range of skills of allied health practitioners. It is evident also that CDCs will require not only the cooperation of the Medical Faculty in establishing continuous and meaningful relationships with the local Centres for clinical training programmes of students, but also the provision of considerable numbers of specially trained nurse-practitioners and physicians' associates. In this regard, encouraging developments are already taking place in the province.

Clearly Health Sciences patterns of instruction must continue to change in order to reflect new social needs. It will be preferable for changes in courses of University instruction to come about through the processes of discussion

and recognition of social needs rather than through the direct commands of government; to this end, specific proposals are made in section 8 below. The hope expressed here is not only that appropriate university authorities will be represented on public advisory bodies, but also that community health centres will be recognized by university Schools of Health Sciences as legitimate and appropriate venues for summer work by students and for the provision of clinical experience and training for the various health disciplines, including physicians.

With regard to small rural hospitals and their relationships with Community Development Centres, it is clear that unnecessary duplication of services must be avoided. CDCs may, in many areas, be physically located in existing small hospital buildings.

In many of the provinces of Canada it seems likely that total hospital bed capacities may be reduced in the foreseeable future. Ontario's Minister of Health, for example, has been quite explicit in his statements on this point; the Hastings Report is equally explicit in its assumption that,in the interests of cost control and economy, ambulatory clinical facilities must be substituted for hospital beds. There are also other important reasons why many provinces will have to give serious attention to

the long-run possibilities of reducing hospital beds and even taking steps to close existing small "cottage" hospitals. When a physician retires or leaves a small community, it may not be possible to replace him, and in the absence of a medical practitioner, there is little or no point in trying to keep a small hospital open.

All politicians and administrators are keenly aware that the closure of a hospital in a town or village can work great hardship on the community. Recent experience demonstrates that most communities will fight hard to maintain their hospital facilities or indeed to expand them. However, not all local citizens are always aware that in fact there are effective and perhaps even more attractive alternatives available to the continuation of a small hospital facility. These alternatives must be made known to, and carefully considered by, individual communities. For example, existing hospital buildings and acute care beds could be transformed, without loss of jobs or socially useful public investment, into various locally-desired mixes of:

- nursing home or old age care facilities,
- day care centres,
- community social and recreation centres,
- holding beds, linked to medical services in a larger neighbouring town by public ambulance facilities,

- community action facilities,
- offices for visiting practitioners,
- offices and clinical facilities for small health teams including nurse-practitioners and/or physicians' associates, well able to provide high quality first-line health care emergency services.

Strong government support for Community Development Centres would indicate to villages in which, through economic necessity, hospitals must close that their closure need not mean the loss of payrolls, public facilities, public investment, or a broad range of essential public services. When the alternatives are known and considered, many communities may prefer to opt for the gradual substitution of CDCs for existing cottage hospitals. On balance many small communities may discover that the creation of CDCs may provide not only comprehensive health care of high quality, possibly even higher quality than now exists in some localities, but also increased opportunities for public investment to be pumped into small rural centres now suffering from population decline. Whatever alternative choice is eventually decided upon, it is essential that the individual citizens most directly affected must have a voice in, and be involved in, the policy decision.

8. The Proposed Scheme for Saskatchewan - METHODS OF PROVINCIAL CONTROL

In recent years the rapid spread of both hospital insurance and medical insurance, plus a growing recognition of the increased responsibility of government to finance and supervise the provision of health care, has thrown enormous new burdens on the shoulders of provincial Departments of Health. The administrative function has increased so rapidly that the senior officers and staff of the Departments have tended to become excessively weighted down with the day-to-day administrative details of simply keeping a massive and complex system in operation. On the whole they have succeeded admirably; few people would dispute that Canada's health system is superior to that of Britain and greatly superior to that of the United States. At the same time, as argued in Part II above, there is a real danger that government bureaucracies have become so overwhelmed with the day-to-day problems of merely maintaining the system and financing existing patterns of health care that there is little time or energy left to devote to innovation. Certainly government *pays* for most health services, but can government adequately *control* them? There is a real danger that the rapid extension of public health insurance arrangements may have tended to

perpetuate or "lock us into" inefficient or obsolete patterns of service. As the responsibility of government has grown, there has also arisen a greater consciousness of the need for government leadership in reforming and re-shaping the system, a realization that government must play a more decisive role in planning and coordinating the system and formulating rational policy decisions.

In this period of rapid flux and change in patterns of health care, it is imperative that the careful formulation of new policy departures be given high priority by the Department of Health. The essential role of administrators is to devise and implement the best methods of fulfilling the goals of public policy; the essential role of the responsible Minister and his Cabinet colleagues is to make choices and to determine the goals of public policy. But Ministers always require precise formulations of policy choices and alternatives, and it may not always be possible for their civil service advisors to provide detailed proposals for a full range of policy alternatives. Civil servants in huge line departments may be so burdened and obsessed with routine administrative details that they have all too little time to consider alternative approaches to future policy problems while they are struggling to cope with the immediate problems of today.

Therefore, it seems desirable that some senior advisors to the Minister be in large measure relieved of day-to-day administrative responsibilities so that they may devote their time to thinking rather than to reacting, and so that they may have time to read, reflect, discuss, and devise new policy possibilities. It may be necessary to separate (so far as may be possible) the burdensome administrative functions from the at least equally demanding function of formulating new policy departures. To put the matter another way, it seems desirable to distinguish the administration of "what is" from the determination of "what ought to be".

It is the policy and planning function which needs more attention. Departmental Research and Planning Branches have been seriously under-staffed in most provinces. The Saskatchewan Department of Health, to its credit, has clearly been moving in the right direction with the creation in 1972 of the new post of Associate Deputy Minister, Program Development, and has also made determined efforts to expand the strengthen its research and planning facilities. The recently announced reorganization of the Department of Health in Ontario, providing for the creation of a separate associate deputy minister and a separate major branch for Health Standards (discussed above) underlines this important point.

If community health centres or Community Development Centres are to emerge rapidly, as this paper has argued they must, these centres will require assistance and support from the top or provincial level of government. Under a separate associate deputy minister for policy and planning, it would be possible for CDCs to be fostered and assisted directly by an agency of the provincial Department. Under such centralized conditions, there might be no need in the short run for the creation of area or regional structures, and control over these centres might be focused directly upon the central provincial administration. On the other hand, such arrangements might make it appear that the creation of community development centres was being imposed by the provincial government from the top down rather than encouraging the emergence of such centres from the bottom up through local initiatives at the grass-roots level. Undoubtedly it would be efficient to control CDCs from the central authority, but this arrangement might seriously inhibit popular participation and local involvement.

For this reason, if real de-centralization of services is to be achieved, it is desirable that some form of regional structure be evolved, as described below, and that the Minister receive advice on policy formulation and policy alternatives from more than one source.

Even the wisest and most efficient Ministers require the fullest possible information as to alternative policies among which they may choose and for which they must accept responsibility. There is no doubt that Ministers of Health in Saskatchewan have been well served by their senior policy advisors in the line department. However, it is always possible that the Minister's departmental advisors may insulate him from, or leave him unaware of, alternative recommendations stemming from non-governmental sources. Because Ministers must make such important and agonizing decisions, the general rule of thumb is that Ministers should receive advice from the broadest possible range of sources reflecting public opinion as well as departmental opinion. Cabinet decision-makers require, more than anything else, information, and the broader and more various their sources of information and advice, the better.

It is significant that both the Castonguay Report in Quebec (Vol. IV, Part II, p. 135) and the Ontario Report of the Committee on the Healing Arts (Vol. III, pp. 16-17) emphasize the utility of senior advisory councils providing alternative sources of advice and policy suggestions to the Minister. Quebec has recently established a Superior Council on Health designed to supplement the advice of the Department officials to the Minister and to express the desires and

opinions of both practitioners and the public. Similarly, the Ontario Council of Health makes policy recommendations to the Minister in that province, and few people doubt that their recommendations have been helpful and influential in the shaping of health policy in Ontario. (See also the discussion of "Provincial Health Planning Councils" in the Report of the Royal Commission on Health Services, Hall Commission, Vol. II, 1965, pp. 230-231).

Accordingly it is proposed that the Government of Saskatchewan should create a senior advisory Council on health policy to reflect a broad spectrum of opinion to the Minister.

The proposed advisory Council should provide for public representation and participation at the top governmental level, and should offer a constant stream of recommendations and advice to the Minister and to the Cabinet. The role of the advisory Council should be, like Bagehot's description of the Crown, "to be consulted, to advise, and to warn". There are occasions, particularly in times of stress or crisis, when this role is by no means insignificant. However, there would be little point in creating an advisory Council if it were to have only such a marginal and limited role; such a Council would be mere "window-dressing", and if its advice were not taken seriously, the Council would quickly

atrophy and die, having no significant functions to perform.

However, the potential *functions* of the advisory Council may be numerous and important. They may be summarized as follows:

(1) *To make policy recommendations* concerning:

- development of new programmes,
- long-term needs for personnel and facilities,
- hospital requirements and plans in relation to other general health services and mental health facilities,
- coordination of the activities of voluntary organizations with government services,
- recruitment and education of health personnel,
- integration of inter-departmental field services (HESS) in the local Community Development Centres.

(2) *To carry out Research*

Government planners seldom have sufficient *information* on which to base decision-making, and governments need *two different types of research*: they need orthodox "monitoring" of the existing system to determine how well it is functioning and where it is failing; they also need more imaginative, biting or "subversive" research, not on what "is", but on what "ought to be" in order to indicate new policy directions.

"Monitoring" research can be carried out in the Research and Planning branches of the various departments and reviewed by the advisory Council.

"Subversive" research could be conducted by the Council either through a small permanent secretariat, or through contracted external research performed by university personnel and consultants, or both.

(3) *To submit annual Reports* concerning their research findings and policy recommendations to the Cabinet, the Legislature, a Standing HESS Committee of the Legislature, and the general public. Publication and broad discussion of these reports would help to increase public awareness and understanding of policy problems.

(4) *To relieve some burdens of Time from the shoulders of Ministers and senior departmental officials.*

Ministers and senior officials are so frantically busy carrying on administration that they have far too little *time* to read, to think and to formulate bold new policy departures. A permanent advisory Council could assist the busy men at the top by formulating crisp policy alternatives, supported by research findings, for Cabinet consideration.

(5) *To permit involvement and participation of both consumers and practitioners in the policy and planning processes.*

Not only is democracy served by broader consumer participation, but also the mutual fear and mistrust that may exist between government and the professions, as well as misunderstandings between the professions, would tend to be broken down when representatives of all these groups work together on mutual problems through the Council.

(6) *To coordinate educational programmes and social services policy.*

> Through their membership on the Council, representatives of University and the community colleges would become more aware of, and responsive to, changing needs for new educational programmes to train new types of personnel. For example, the Council might encourage the University Medical School...in a way in which government could not issue commands...to develop new clinical internship programmes in rural satellite Community Development Centres. The Council might encourage the University to establish arrangements such as Continuing Education courses for practitioners, consultant services for Regions or local Centres, or new courses for Physicians' Associates or Nurse-Practitioners.

Experience in the past has indicated that some advisory bodies tend to wither and atrophy over a period of years, either because their recommendations are neglected, or because of lack of fresh ideas and new work to do. Therefore, it is not proposed that the Health Advisory Council be regarded necessarily as "permanent". The utility of the Council will very much depend upon the quality of its members, whether they are knowledgeable and able to make a significant contribution as well as being merely "interested". If the Council is able to provide recommendations of real worth, it should be continued. But if the Council does not prove to be useful in terms of the production of significant policy recommendations, it should be ended and abolished after a three year trial period.

On the other hand, if the Advisory Council proves to be a success, its membership might in the future be broadened and expanded to include knowledgeable representatives from the fields of Education and Social Services as well as Health. Thus in the long run the Council might become a general advisory body dealing with the entire field of Health, Education, and Social Services.

The initial *structure* of the Health Advisory Council should be as follows:

- A full-time Chairman, assisted by a small permanent Secretariat, plus various part-time members.

- The size of the Council should be not fewer than nine and not more than 18 members.

- Membership should be broadly representative of both professionals and knowledgeable laymen. The membership should be distributed in equal thirds between physicians, allied health personnel, and laymen.

- Members should be appointed by the provincial government after consultation with various professional and public bodies.

- Care should be taken that some representatives of appropriate Faculties of the University and of Colleges find places on the council.

- To ensure frequent infusions of new blood and new ideas, members should be appointed for 3-year terms, once renewable, and paid suitable honoraria on a per diem basis.

- For convenience, when "micro" policy or intra-departmental affairs are being considered, the Council could be divided into appropriate sub-committees; the entire membership of the Council need not meet formally to transact all business, but would review reports of sub-committees.

- Where additional expertise is required, or where expanded public involvement is desired, Associate Members of the Council might be added, either to work with a sub-committee, or with a special-purpose Thrust Group as a satellite of Council. Associate Members need not necessarily sit with Council in formal meetings, and might be appointed or co-opted for short periods of time only.

- To avoid either the appearance or the reality of government or departmental domination of the Council, the ex officio representative of the Department on the Council should *not* be the deputy minister; the appropriate liaison officer with the Council might well be either the Director of the Research and Planning Branch or an Associate Deputy Minister charged with Policy and Programme Development.

- The Council should meet at least once a year with the HESS Co-ordinating Committee of Cabinet.

- The Council should publish an Annual Report which would be tabled in the Legislature and scrutinized by a Standing Committee of the House.

- Final drafts of policy recommendations or research reports produced by the Council should normally be

made public as soon as they are completed, and any such documents must be made public within at least six months of their submission to the Cabinet.

- The Council should receive from the Legislature an annual grant of funds sufficient to enable it to carry out its duties independently, and sufficient to finance research projects either internally or externally, or in conjunction with Regions and/or local Community Health Centres, particularly where pilot projects are involved.

- For purposes of information and liaison, the provincial Ombudsman or complaints Commissioner should be an ex officio Associate Member of the Social Development Council.

A principal merit of the proposed Council would be the *involvement* of selected representatives of a wide variety of people in the discussion and formulation of health policy. The Council would of course give suggestions and recommendations, not commands, to government, but in so doing it would feel that it was participating in the formulation of public policy. Equally important, the general public would be reassured that representatives of consumers would be participating with administrators and practitioners in the process of policy discussion. At the moment there are few if any places where representatives of the various groups most directly involved in health care can regularly meet and discuss policy issues. The Council would provide regular opportunities for physicians to sit down with allied

health personnel, for nurses and physiotherapists to exchange views with optometrists and pharmacists as well as physicians, for consumers to discuss mutual problems with practitioners, for health sciences educators to interact with hospital administrators and professional practitioners in the field, and for representatives of all these groups to make known their problems and their policy proposals to the government. The regular functioning of the Council might well assist in breaking down existing misunderstandings and barriers between these groups which inhibit the development of inter-disciplinary cooperation and the emergence of the health team. In short, it is difficult to see how the deliberations of the Council could do other than assist in the creation of a mood of cooperation, participation, and involvement on the part of various groups, both practitioners and consumers.

To be optimistic, we could predict that the functioning of the Council could result in new and useful policy recommendations which would be helpful to both the government and the groups involved.

To be pessimistic, we could foresee that the deliberations of the Council might not result in useful proposals for policy innovation. If that were the case, the Council could be abolished after a three year trial period.

Prediction is always hazardous, particularly where matters of broad public involvement and participation are concerned, but the view expressed here is decidedly optimistic. Since the Council would not meet more often than once a month, its cost would be minimal and it would not place any burden of time on the senior administrators in the line department; only the associate deputy minister for programme development would be directly involved. Then too, the Council could perform particular tasks at the request of the Minister. The Council could carry out research studies, give opinions upon, or make policy recommendations upon, problems presented to it by the government. Thus the government would have the opportunity to seek external advice and to float trial balloons concerning policy innovation prior to its implementation; at the same time, the public and the health practitioners would be assured of being informed and consulted on policy matters, and would be further reassured that they could have regular and open lines of communication to government enabling them to make known their views and their policy recommendations.

From time to time the advisory Council could add to its numbers temporary Associate members on special task forces or sub-committees to study particular problems.

This would enable the Council to broaden its base of public involvement and participation, and also to secure additional expertise on particular issues, without enlarging its formal membership to an unwieldy size. This procedure has been frequently used by the Ontario Council of Health with impressive results.

Attentive readers will note that a Health Advisory Council of eighteen members could not possibly provide direct representation for all of the forty or more groups of health practitioners ranging from podiatrists to dietitians, speech therapists to hospital attendants, dental hygienists to laboratory technicians. It is here that temporary Associate membership on the Council may prove very useful. The special knowledge and needs of various groups can find expression through membership on numerous *ad hoc* sub-committees and task forces studying particular problems. Ophthalmologists and optometrists, for example, would have a special interest in the development of screening programmes in the schools to examine children's eyes, but much less interest in a task force study of, say, nursing education. Similarly, physicians and pharmacists would bring special expertise to bear on a review of formularies for generic drug prescriptions, but have less interest in evaluating a

program of paediatric dentistry. Task force studies carried out by temporary Associate members of the Health Advisory Council would add breadth and flexibility to the representative function of the Council, bring special expertise to bear on particular problems, and also result in constructive new policy recommendations.

In this manner, special sub-committees or task forces of Council could carry out short-run studies of particular problems at the request of either: (1) the Minister and the department, (2) an individual Health Region, District, or community health centre, or (3) the Health Advisory Council itself.

Although the potential utility of such studies, and of the Council, can scarcely be doubted, it may reasonably be objected that the Advisory Council would constitute yet another pressure group to bedevil the government. Would the Council in some way harass the Minister? The answer is an emphatic: YES. The Council would indeed be a pressure group, but it would be an "open" rather than a covert group, working through orthodox public channels, highly visible, dominated by no one, and representing no special or narrow interest. And on the other hand, the Council might also serve as a line of defence for the busy Minister, enabling him to deflect the private demands of special pressure groups by referring them to the H.A.C.

The work of the Advisory Council may provide a useful and participatory catalyst to hasten change and innovation. It should be emphasized that one important reason for increasing popular participation is to make things harder for politicians and bureaucrats, not easier, and to create new pressures to accelerate reform. It will be beneficial to the public interest if the Health Advisory Council provides "relentless encouragement" toward innovation directed constantly at the cabinet, the department, district and regional units, and all health care practitioners.

The author recognizes that advisory Councils are viewed with some scepticism by most civil service administrators and many cabinet ministers. Admittedly the policy recommendations made by advisory Councils can prove inconvenient to a department and to a minister. But that fact may only underline and demonstrate the potential utility of advisory Councils. It is salutary, and very much in the public interest, that civil servants and ministers should be goaded and prodded by external forces; all public officials may potentially benefit from being exposed to the widest possible variety of conflicting opinions. Advisory Councils certainly can be a thorn in the side of government, but surely it is essential to the democratic process that

citizens enjoy the widest possible opportunity to stick thorns into public authorities and force them to be responsive to the public will.

It must be understood that an advisory Council has no executive authority. It cannot and must not attempt to implement policy or interfere with administration. The Minister makes the decisions, and the Minister remains responsible. Advisory Councils can make recommendations only; they cannot enforce those recommendations. Moreover, it is clear that the government must retain ultimate responsibility and must be the final decision-maker in control of resource allocation. Advisory Councils can supplement but never supplant the processes of ministerial responsibility.

If, for example, the government decides to proceed with the creation of community health or development centres, it will be the responsibility of the Department of Health to establish the necessary guidelines, including the budgetary guidelines, within which the centres must operate. The proposed advisory Council could review and make recommendations concerning the adequacy of those guidelines, but could not interfere with their application and enforcement.

While an advisory Council would be harmless at worst, and a source of innovative policy recommendations

at best, we must still face the question of what the harassed Minister must do if he is presented with contradictory advice by his senior departmental officials on the one hand, and the advisory Council on the other. The answer is quite simply that the Minister must choose. The essence of responsible government is that the Minister, in consultation with his cabinet colleagues, must make the final decision; the buck stops on the Minister's desk. Rational men must always make agonizing decisions, but it is always desirable that those decisions should be made on the basis of the broadest possible information concerning alternative choices. If the Minister decides to follow the policy recommendations of his departmental officials, it does not mean that the contrary recommendations of the advisory Council are either evil or silly; it simply means that their recommendations are different. On the other hand, if the Minister chooses to follow the policy recommendations of the advisory Council in preference to the proposals of his departmental officials, it does not mean that those civil servants are necessarily wrong or incompetent. It merely means that rational men of goodwill may express different interests and divergent views. It may or may not be possible for the Minister to reconcile and make compromises between divergent recommendations. His choice may not be made easier, but it may be a better

informed and more rational choice made in full awareness of the broadest possible range of competing alternatives. Differences of opinion and conflict are entirely normal in all human affairs. No responsible Minister of intelligence and integrity will want to exercise his power to choose and make final decisions in the absence of information concerning the full range of policy alternatives.

Thus the receipt of contradictory advice should not be regarded by a Minister as either surprising or disastrous. On the contrary, competition in the realm of ideas is always salutary. If the recommendations of the advisory Council agree with the recommendations of the Department, the Minister should be reassured; if the recommendations of the advisory Council are contrary to those of senior civil servants, the Minister possesses a broader foundation of information and ideas on which to base the final decision for which he must bear the responsibility.

9. The Proposed Scheme for Saskatchewan - REGIONALIZATION

The preceding sections have outlined a proposed scheme for reform of the health care system at the "bottom" or community level through the creation of Community Development Centres and at the "top" through new methods of provincial

decision-making and control. The intermediate or middle level of potential reform is much the most difficult to analyze. Although we have reviewed various approaches to de-centralization and/or regionalization in the provinces of Ontario and Quebec as well as the recommendations of the Hastings Report, the writer believes that none of these proposals or precedents is entirely appropriate or applicable to the particular circumstances of the Province of Saskatchewan. It has been emphasized above that proposals for "regionalization" are by no means identical with, or likely to produce, "de-centralization", and that most of the current approaches to regionalization in Canada reflect the experience and assumptions of predominantly eastern commentators used to dealing with large concentrations of urban populations.

Still, regionalization remains an extremely fashionable concept. Many observers tend to assume that some scheme of regionalization will facilitate achievement of the general goals of health policy. That may be true, but a note of caution and scepticism should be entered here.

If it is agreed, as argued above, that the major goals of provincial health policy must include increased public access to health services of high quality, restraint of total health costs, and increased public involvement and

participation in the health care system, there are solid grounds for doubt that regional arrangements will necessarily facilitate the achievement of these goals. It seems fair to mention that Saskatchewan's sole experience with regionalization in the health field, the Swift Current Health Unit, has not been conspicuously successful either in reducing total costs or in achieving maximum public involvement in the health care system.

It is understood that the Government of Saskatchewan, like the governments of most other provinces, desires to facilitate extensive reform and innovation in the health care system, particularly with regard to cost control, and hopes to bring about increased public involvement and participation in the health system. Whether these goals can be achieved through regional arrangements is open to serious question. There are strong arguments to be advanced in favour of regionalization, but there are several alternatives to be considered, and if our analysis is to be realistic we must bear in mind several serious considerations.

First, most current proposals for regionalization appear to assume a population base as large as, or at least half as large as, the total population of Saskatchewan.

Second, there is little or no reason to believe that regional structures would easily achieve significant economies.

On the contrary, regional administrations might well constitute additional pressure groups making constant demands upon the provincial treasury for more money to be spent in their particular areas.

Third, geographical realities in Saskatchewan with its thinly scattered population may negate or make extremely difficult the achievement of real public involvement in regional structures; sheer physical size may make regional administrations relatively abstract and distant from local communities.

Fourth, maximum public involvement and participation may be most easily achieved at the local or community level rather than at the level of regional administration.

Fifth, to overcome apparently existing public inertia, and to overcome existing barriers to innovation, it may be necessary to assert strong policy thrusts from the most powerful level of political authority, the level of the central provincial government; strong initiatives appear to be required from the centre if the pace of institutional change is to be accelerated.

Sixth, there is some danger that the interposition of a new level of administrative authority might not only increase administrative costs and complexities, but also place additional barriers between local communities and the

provincial government, and thus might thwart rather than facilitate direct public involvement and local control over community health care facilities.

Therefore, we must tread warily in matters of regionalization. Indeed it is difficult to understand the apparently fashionable wave of enthusiasm in some jurisdictions for the general concept of regionalization *per se*. Some of its current advocates in provinces such as Quebec and Manitoba may later find themselves disappointed by the realities of regional experience. Perhaps we could gain additional perspective on the issue by putting some of the previous six points in the form of questions and tentative answers.

Would regions effect major economies or rationalize and redistribute services? Probably not, because the most expensive elements of health care, the services of specialist M.D.s and the big urban hospitals, are concentrated in only two cities, Regina and Saskatoon. It is difficult to see how regional units in rural areas could have much effect on these elements of concentration and greatest cost. Would regions increase public participation in the system? They might, but such participation could be achieved at least as easily through the creation of an advisory Council at the provincial level plus representative boards for the Community Development Centres at the local level. If the

regions were small enough to be close to the people, increased public involvement might be achieved, but on the other hand, the smaller the region, the less likely it is to bring about either rationalization and equalization of services or significant reductions in total costs. It remains an open question as to whether the provincial government will place more emphasis on the goal of popular involvement or on the goal of cost control; it is at least apparent that there are potential conflicts and trade-offs between these two goals.

For these reasons, the government may want to give serious consideration to rejecting the concept of regionalization. It is entirely possible to achieve a significant degree of de-centralization, through the creation of Community Development Centres enjoying some form of local control through representative boards, while at the same time maintaining ultimate control over policy and finance in the hands of the provincial government. CDCs could be administered and fostered directly by the Department. A separate Branch of the Department could be established for the purpose of creating, assisting, and supervising the rapid emergence of CDCs. De-centralization and local participation could be effected through broadly representative boards, including elected representatives of the lay public, which would shape and direct community centres to meet

local needs and requirements. There might be a representative board for each individual CDC, or for groups and clusters CDCs in small Districts as suggested in the Hastings Report. We should note in passing that the Hastings Report, while it emphasizes de-centralization of services and local involvement, makes no explicit provision for regional structures. Thus *de-centralization without regionalization is one alternative* which may deserve consideration.

Such arrangements would not preclude the later emergence of regions or regional councils. After significant numbers of CDCs have been established and accepted, regional structures might gradually evolve through the initiatives of the local CDC Boards. Experience may suggest to these Boards the need for area-wide integration of their facilities, and they might well begin to demand the creation of regional councils to meet their perceived needs. If and when such demands arise, the provincial government could respond to them, confident in the knowledge that real need and public support already existed as a secure foundation for regional structures.

However, it is evident that a strong *case for regional structures* can be made. If regional patterns are to be adopted, there are several alternative structures which must be considered.

The *size* and number of the regions is clearly important. We have suggested above that larger units are more likely to rationalize services and restrain costs, but that smaller units offer greater hope of public participation and involvement. If cost control were the primary objective of a regional scheme, the province might be divided into three vast regions based upon Regina, Saskatoon, and Prince Albert. If on the other hand participation and involvement were primary considerations, the regional units might be very small in terms of both population and geographical area. At this extreme we could conceive of rural units serving populations as small as 10,000, embracing only a few towns along a connected highway route. But such an arrangement would be no more than a District of community centres as contemplated in the Hastings Report, and would be much too small to bring about effective rationalization or economies of service.

The compulsions of the trade-offs involved between competing objectives suggests the necessity of making a compromise between units of minimum and maximum scale, and the establishment of approximately twelve regions in the province. These regions might be: Swift Current, Moose Jaw, Weyburn, Regina, Regina Rural, Rosetown, Saskatoon, Saskatoon Rural, Yorkton, Melfort-Tisdale, Prince Albert and North Battleford.

The writer possesses neither the intention nor the competence to attempt to draw arbitrary lines on a map indicating desirable regional boundaries. However, provisional proposals for the delineation of regional boundaries have already been drawn up. The existing interdepartmental HEW Technical Committee, after considerable study, has suggested tentative boundaries with elaborate overlay maps indicating possible lines of regional demarcation. The HEW Technical Committee appears to have done careful and useful work. The writer can find no major fault in its conclusions, and urges the most earnest consideration of its findings.

If regional boundaries should come into dispute, two possible solutions might be applied. Either the existing and independent Electoral Boundaries Commission could be asked to adjudicate, or the principle of "local option" could be applied permitting the representative boards of CDCs themselves to decide which region they wish to join.

Ultimately the regional boundaries are not very important except insofar as the total area and population of the region are concerned, and with the proviso that existing municipal boundaries should not arbitrarily be cut or violated. In fact the precise regional boundaries are not very interesting or significant except to the people

living on or near the boundaries, and application of the principle of local option should satisfy their needs. What is important is not the arrangement of lines on a map, but rather what goes on within those lines in terms of improved quantity and quality of public services. If services are improved and genuine community involvement is achieved, boundary lines can always be altered later to satisfy particular complaints; if services are not improved and no feeling of community emerges, the size of regions or the entire regional experiment could be changed. In short it is only the principle and the effectiveness of regional structures which count, and boundary lines can always be adjusted.

More important is the scope of public services to be provided within a regional framework. Several alternatives exist here. Initially the region could be concerned exclusively with the provision of health services, and the existing divergent boundaries of Public Health Regions would have to become reconciled or coterminus with present Mental Health Services Units, or vice versa. As a second stage, the health service region could expand the scope of its services to include also Education and Social Services so that greater integration of these three departments could be achieved at the field level. As a third stage, Agricultural and Municipal

services could be integrated with the regional administration. The Department of Agriculture has already achieved considerable de-centralization through regional units, and municipalities are of particular importance to regional schemes because of their immediate control over housing policy. There can be no doubt that community health or community development centres as well as regional units inevitably will become involved in housing policy. If community involvement and participation is to become real it will require improvement in the quality of rural life and change in patterns of living. It is clear that many people now occupy hospital beds who should be in nursing homes, and at the same time that many people are in old age or nursing homes who should be living in their own dwellings and receiving the services of organized home care. The relative social isolation of the ill, the infirm or the aged is a major social problem. Thus it is evident that aroused populations, organized through Community Development Centres or regional structures, will of necessity become involved in the formulation of local housing policy and arrangements.

In the long run, regional structures should include all operational and service functions of government. If they are to be fully effective, regional units must be concerned

with Health, Education, Social Services, Agriculture, and Municipal Affairs.

The powers and *functions* of regional units could be of three kinds: a) administrative, b) advisory, or c) autonomous. Here again the provincial government must choose between these three types of regional arrangements. In the first instance, in order to achieve integration of the services of various operational government departments, the central office of each region could include an area co-ordinating officer representing each major service department or, preferably, a single area co-ordinating officer could be appointed by the provincial government to assume responsibility for the integration of all public services in the region. A single interdepartmental area co-ordinating officer could ensure more convenient access for rural populations to various public services in the same locality on the same day. Under this option, we are contemplating the use of regional officers to achieve increased efficiency in the provision of public services at the local level as administrative agents for the central line departments. These regional officials would be directly responsible to the Cabinet, or to the HESS co-ordinating committee of the Cabinet, and would perform administrative functions only.

To supplement the activities of the area co-ordinating officer, there could be established representative regional councils to advise the administrator and the provincial government as to local needs, priorities, and deficiencies of services. Such regional advisory councils could have a voice in planning and the formulation of policy by feeding their recommendations to the provincial departments through the provincial advisory council. They might advise and assist the area co-ordinating officer by indicating to him perceived deficiencies of service as well as local needs, preferences, and priorities.

But regional authorities would become more significant and effective if they enjoyed at least some degree of autonomy. Ability to influence or control regional budgets allocated by the province on a global basis would give real bite and authority as well as increased feelings of responsibility to regional councils. At the regional level, true de-centralization and direct public involvement seem to require some degree of fiscal as well as planning authority.

The inescapable conclusion here is that if regionalization is to become meaningful and capable of achieving truly de-centralized patterns of service and community involvement, there must be a real diminution of central government and line department control plus a real devolution of autonomy to the regional units.

Whether the regions can obtain sufficient quality of talent for administration and assume an appropriate degree of fiscal responsibility must remain an open question until experience demonstrates the results. It may be advisable for provincial governments to encourage experimentation with regional arrangements before they make a total commitment to the principle of regionalization. As demonstration or pilot projects, the provincial government should establish area co-ordinating officers and regional councils enjoying a degree of autonomy in at least two regions, possibly in Swift Current and in Yorkton where there has already been indication of strong local initiatives being taken. It might also be desirable to experiment with the creation of at least one region in a major urban centre, either Regina or Saskatoon, so that the results of regional autonomy may be more fairly assessed over a trial period of at least two years.

Obviously regional structures could perform a major public service if they could achieve rationalization of services, reduction of costly duplication of services, and the imposition of cost restraints on the health care system. Clearly one function of regional structures must be cost control, particularly with regard to expensive hospital facilities. Saskatchewan has a very high ratio of hospital

beds per thousand of population, and also has an unusually high number of small hospitals of apparently uneconomic size. Authorities in the field of hospital administration are agreed that nothing less than a twenty-five bed unit is efficient or optimal for high quality patient care; some would argue that nothing less than a fifty bed unit can be an efficient size for a modern hospital. But Saskatchewan has approximately eighty hospitals possessing fewer than twenty-five beds. It is fair to suggest that the Province of Saskatchewan possesses more hospital beds than are required. For entirely understandable reasons, each local community desires to maintain or indeed to expand its hospital facilities, and there appears to be a high degree of competition between towns and communities in terms of total numbers of hospital beds. This competition is by no means efficient and tends to increase total health costs.

A major factor in the creation of excessive hospital bed capacity in Saskatchewan has been the relatively autonomous local hospital board and the traditional Union Hospital Districts. Each Union Hospital District has the authority to levy a property tax or mill rate on its citizens for the financial support of the local hospital, but these tax levies vary across the province in an extremely

iniquitous manner. The tax spread varies across the province from less than one mill up to 8 mills, and the tax rate is generally unrelated to the economic productivity of the property taxed. In some cases Union Hospital Districts have levied no property tax for three years or more, and in some cases the mill rate has been heavy but the Union Hospital District remains in debt.

The obvious inefficiency and inequity of this arrangement argues strongly for the revision or abolition of existing Union Hospital Districts and the substitution either of a province-wide hospital planning authority with the power to levy uniform tax rates, or broad regional control over hospital financing and facilities. In either case, it seems apparent that the existing Union Hospital Districts should be abolished.

Since local people are more knowledgeable concerning local requirements than are departmental officials in Regina, it seems reasonable to suggest that regional councils may best be able to replace Union Hospital Districts and to make decisions concerning optimum hospital bed capacities in a particular area. If Saskatchewan proceeds with the creation of regional structures, the representative regional council should be responsible for deciding upon additions to existing hospital bed capacity or for reduction of such

bed capacity and the possible closure of expensive and socially redundant hospital facilities.

Thus the creation of regional health councils implies the ending of autonomy for individual hospital boards and the abolition of Union Hospital Districts. Public concern for rising hospital costs necessitates rationalization of hospital services and the elimination of expensive duplication of hospital facilities. If regional planning arrangements are proceeded with, they clearly imply control by regional authorities over any expansion of hospital bed capacity and over reduction or gradual elimination of redundant hospital units. Thus a major advantage of regional structures could be the reduction of total hospital costs within a given area. However, as argued above, the substitution of community health or development centres may increase the quality of local health care and provide attractive substitutes for existing small hospital units.

If the Union Hospital District Act were to be abolished and replaced by regional structures under a Regional Act, hospitals would become "centres" with their own boards similar to those of the Community Development Centres, but responsible to the regional council.

The attractive possibilities of using regional councils as agencies directly involved in cost control emphasizes the

importance of firm policy guidelines being established by the province through the Department. Some degree of local variation is necessary, but provincial guidelines must be drawn up, stating generally acceptable and desirable maxima and minima for services and facilities. Pressure exerted by local communities for the maintenance or expansion of existing but redundant facilities could be more powerful when brought to bear on regional councils than on the provincial government, and so it is essential that the Department establish targets for the regions. Policy guidelines should include statements of maximum and minimum hospital beds required per 1,000 of population, a range of desirable mixes of medical and non-medical personnel plus ratios of personnel to population, tolerable cost levels per unit of service, levels and types of beds required within regions (acute, holding, mental, nursing home, rehabilitation beds, etc.), conditions under which public funds will be allocated, permissible budget ranges for pilot projects, sources of material for "public participation training programmes", methods of creating local "user's committees", and generally the shape and cost parameters of the health services system.

If regional arrangements are to achieve de-centralization rather than merely to conceal centralization, it is essential that funds be allocated to the "centres" through the regions.

Any scheme of genuine de-centralization and local control pre-supposes the substitution of *global budgets* for existing line-item budgets. At present budgetary arrangements for hospitals and other health facilities are excessively rigid and unimaginative. There is evidence to suggest that many hospitals spend more money in the final quarter of the year than they do in the earlier quarters, indicating the determination of local hospital boards and administrators to spend up to the very limits of their budgets for fear of cut-backs in the following year. This practice scarcely encourages economizing or sound administration.

Global budgets must be related to performance and units of service provided in terms of both volume and quality of service. Negotiation would produce agreement on a "base year" to be used as the bench mark for future expenditures.

If economies are to be effected it is important that global budgetting arrangements be emphasized and worked out by the Department in great detail, but emphasizing the principle of considerable fiscal autonomy for regions and for local centres in the allocation of their particular blocks of resources. Global budgets, in contrast to existing procedures, must provide strong *incentives* for the various units to economize. If a region or a centre succeeds in

reducing costs and saving money, it must not be penalized for its success, but must have the right to apply at least some portion of that money to other social choices related to improved public services. Only in this manner can true de-centralization be achieved and sound administration encouraged.

We must bear in mind that the administrators of many large hospitals spend enormous quantities of public funds. In many provinces hospital administrators spend more money and bear greater responsibilities than many officers of the line departments; the hospital administrator in the field may also have a higher salary than his counterpart in the line department. Therefore, it is scarcely surprising that in some provinces the administrators in the line departments lack a degree of credibility in the eyes of hospital administrators. This situation encourages hospital administrators to demand all the money they can get, and more, from the departments, and sound economical administration is further discouraged. Through the provision of incentives to economize, global budgeting procedures offer the only real hope of inhibiting cost spirals.

One further note must be added with regard to budgeting. Global budgets to be effective must include estimates of payment for health practitioners and personnel. Practitioners

have the right to expect adequate, fair and competitive remuneration which reflects their professional status and experience. At the same time, payment methods must permit health planners to prepare budgets with reasonable precision and must also be designed to promote multi-disciplinary teamwork in the various health centres. However, it is difficult to see how team practice and the planning and administrative problems of the system can be reconciled with present fee-for-service payment mechanisms.

The Hastings Report has been frank in its discussion of this problem. The Hastings Committee notes that approximately one-third of the physicians in Canada already obtain their incomes from some method or combination of methods other than pure fee-for-service, and goes on to observe: "many appear to be willing to work under other payment arrangements provided some degree of choice of method and/or combination of methods is open to them and the levels of remuneration are deemed fair and adequate. It is likely that more would be willing to do so in return for the security of a planned system of remuneration, incentives, and other benefits which could be arranged." The Report concludes that although "it is difficult to recommend any one specific form of payment, the Committee agrees that the present form of

fee-for-service payment makes the achievement of the objectives of the community health centre impossible" (p. 21).

The Hastings Report also notes, in relation to budgetary matters and economizing, that there should be at the provincial level "an independent body with its own budget and staff with the responsibilities to monitor and evaluate the performance of existing and new programmes and of the health services system as a whole and in cooperation with the universities, professional groups, and other expert resources" (p. 43). This recommendation fits nicely with the proposal in section 8 of this paper to create a Health Advisory Council. The intention here is that the Council should be responsible for evaluating the performance of both old and new programmes as the basis for its policy recommendations.

The major problem in this regard is that we lack sufficiently precise and sophisticated techniques for evaluation. It is extremely difficult if not impossible to measure quality of services, and as yet our evaluative techniques remain relatively crude. Very little work has yet been done in Canada to apply cost-benefit analysis to health services. Although existing techniques are by no means satisfactory, this fact only serves to re-emphasize the importance of the proposed advisory Council and the recently created associate

deputy minister for program development.

Turning back to our consideration of the proposed regional structure, the *composition* of the regional council remains to be described. In addition to its area co-ordinating officer, each region should have a council composed of not fewer than nine or more than eighteen members. A smaller group would not be sufficiently representative, but a larger group would be too unwieldy. It is proposed that membership on the Council should be initially by appointment of the provincial government after consultation with local and regional interests. Later, provision might be made for the addition of elected representatives of the community, but it seems unnecessary and unwise to make provision for elective membership until the regions have been organized and established. It is proposed that membership on the Council be apportioned in thirds, representing professional practitioners, allied health disciplines, and members of the lay public. At least two members of the Council must be selected to provide representation for hospitals; these representatives might be either or both hospital administrators or persons experienced on local hospital boards. To provide liaison with the local community centres, it is desirable that the initial membership of the regional council be weighted in favour of persons already involved on the boards of the local service centres.

10. Recommendations

IT IS RECOMMENDED:

(1) That government policy should proceed on the understanding that Operational Services should be de-centralized, but that ultimate control over the allocation of public resources must remain centralized in the hands of the provincial cabinet.

(2) That in the short run the main thrust of government health policy should be focussed on the creation of community health clinics or Community Development Centres, multi-discipline ambulatory facilities providing health care and other social services through team practice, as described in this paper and in the Hastings Report.

(3) That before final decisions are made, consideration be given by the cabinet to two alternative forms or patterns of de-centralization:

a) the creation of Community Development Centres (CDCs), operated by representative community Boards providing for local decision-making and involvement, but created and administered through a new Branch of the Department of Health without the establishment of regional structures in the short run, or

b) the creation of a regional structure to foster and administer the CDCs.

(4) That if regional structures are decided upon favorably by the cabinet, the government should proceed gradually with the creation of two or three regions on an experimental basis prior to the implementation of a general scheme of regionalization.

(5) That any regional structure should be designed deliberately to take into account important policy trade-offs between effecting economies and maximizing public

participation; that regions in Saskatchewan should be approximately twelve in number, as suggested by the HEW Technical Committee, neither so large in area as to inhibit public involvement nor so small as to preclude scope for rational planning to effect economies and inhibit costs.

(6) That any regional scheme should include an area co-ordinating officer appointed by the province and responsible for the integration of services, and an (initially) appointed Regional Council of between nine and eighteen members to advise the cabinet - through the co-ordinating officer - as to particular needs and priorities in the area.

(7) That if regionalization is to achieve genuine de-centralization, it must rapidly evolve toward both elected membership on the Regional Councils and toward significant financial autonomy through global budgetting arrangements including real incentives to economize.

(8) That regional structures, which might initially emphasize the administration of health services under the Department of Public Health, should, if successful, be broadened to include participation of the Departments of Education and Social Services (HESS), and possibly also integrate the provision of certain Agricultural and Municipal services, particularly with regard to the formulation of housing policies within the regions.

(9) That in order to facilitate innovation in the organization and delivery of health services, the Department should be reorganized to separate more clearly the administrative functions from the policy and planning functions.

(10) That the province should create a broadly representative Health Advisory Council, appointed for a three year period to advise the Minister, and include representation of the senior health professions, allied health personnel, and the lay public; that the Council should have a real degree of independence, including a separate budget and a small separate staff, but also be able to carry out special studies or formulate recommendations on particular problems as requested by the Minister; that if the Council proves useful it could be broadened to include advisory functions relating to Education and Social Services (HESS), but if it does not prove useful to the public, the functions of the Council should be terminated after three years.